The Public Health Nurse

Volume XXII January, 1930 Number 1

The PUBLIC HEALTH NURSE

Official Organ of The National Organization for Public Health Nursing, Inc.

Volume XXII JANUARY, 1930 Number 1

Happy New Year

The beginning of a new year may be an exhilarating or a depressing event, depending upon a variety of circumstances. Are we idle or have we plenty to do that is worth doing; are we in a rut or are there enough ideas coming along, our own or someone's else, to keep us on our toes? When we get perplexed or feel inadequate to handle the situation alone is there any person, group of people, or organization to which we may turn to think or work the situation through with us? Public health nursing offers each one of us a chance of being productively busy, stimulated, challenged, and of being able to share our work with others. Happy New Year to you!

Katharine Tucker

Relation of the Public Health Nurse to Tuberculosis

By Kendall Emerson, M.D.
Managing Director, National Tuberculosis Association

THE complementary nature of the two professions, nursing and medicine, is too apparent to require debate. A change in the policy or fashion of one is bound to have its reflection in the other. Fifty years ago general practice was the prevailing mode among physicians. Specialization had infected them but mildly and the contagion had at that time not begun to spread among the nurses. But the following quarter century saw a marked change in this situation brought about as a logical need by the astounding rapidity of scientific discovery. During this period the accepted division of practice into surgery and internal medicine was succeeded by extensive specialization in each branch of the art.

The end of the nineteenth century also marks the period when specialization in nursing work began, and the beginning of the twentieth saw a well defined separation of the profession into two groups, one, by far the larger, of private duty nurses, the other, the small group of public health nurses with disease prevention as an important share of their work. From this time on specialization advanced with great rapidity in both groups.

TUBERCULOSIS AN INDIVIDUALISTIC DISEASE

It is not by chance that the first disease to invite special attention in the public health nursing field should have been tuberculosis. And it is interesting to review the causes of this priority. To understand them one must turn to a consideration of some of the peculiarities of the disease itself and enquire into the reasons why nurses are so fundamental an element in a program directed to its control.

The name tuberculosis comes from the word, tuber, a thickened portion of the root of a plant, of which the potato is the commonest example. Early observers recognized characteristic little yellowish specks which accompanied diseases of many different organs of the body. Laennec showed that wherever these occurred they represented the same process and were probably manifestations of a single disease entity though occurring with such wide distribution. Later when Koch had identified the tubercle bacillus Laennec's contention was upheld by finding the germ in these tubercles however widely they may have been scattered through the various organs of the body. The presence of typical tubercle means tuberculosis and is characteristic of only one disease. This is the fact which individualizes tuberculosis.

Now the tubercle bacillus belongs to a rather small group of related bacilli known as the acid-fast group which has certain easily recognized but not fully understood characteristics. These bacteria grow only on certain media and under certain conditions, they have also their specific methods of attack upon living animal tissue. For example, the tubercle bacillus apparently lives and multiplies only in one cell of the human body, the so-called monocyte. Such scientific knowledge is of value in explaining why tuberculosis is so individualistic a disease and suggests reasons for the difficulty of finding a specific cure. Research has not gone far enough as yet to explain exactly how the germ works or what bio-chemical mystery underlies this marriage of the tubercle bacillus with the complacent monocyte.

RELATION OF THE PUBLIC HEALTH NURSE TO TUBERCULOSIS

What relation have the above observations to the nurse in the tuberculosis field? The reply is that they furnish the clue which explains the philosophy of her existence. Added to

the bio-chemical basis for this philosophy is the social fact that the disease itself has probably the widest endemic distribution of any of the distempers which prevail in the civilized world. Its mortality, now fortunately reduced to sixth place in the list, stood first as a cause of death when the earlier public health nurses appeared in the field. Right here, however, it should be stressed that the rapid fall in death rate must not be too optimistically interpreted. Recent studies of Dr. Opie in Philadelphia would seem to prove that mortality is no index of morbidity and that infection of the population with the tubercle bacillus is not less wide-spread than it was some thirty years ago. The reduction in deaths is due to arresting the disease and prolonging the lives of an annually increasing number of cases found in the incipient or very early stage.

In the case of the vast majority of diseases the discovery of their cause has led gradually to some specific and effective means of treatment, either by drugs or serums or vaccines. In tuberculosis no such means has as yet been found. While prevention is desirable in all diseases it becomes imperative in those for which, once acquired, there is no specific remedy. "The public health nurse is the fulcrum upon which rests the community's resources for the prevention of tuberculosis. Clinics and physicians are helpless without her." This, then is the second "*Why*" of the nurse's philosophy. With her as a fulcrum there may be pried into the obstinate minds of a community the health knowledge needful to secure protection to its constituent members from the initial infection with the germ of tuberculosis, or, if infected, to insure them against the development of the disease in an active form.

THE NURSE AS EDUCATOR

Admitting that we have a disease which stands out alone in certain of its individual characteristics, admitting that we must have a means of educating the public in the manner of its prevention, may we not still ask why this is the special duty of the nursing profession. Why are not other educational channels equally effective? The answer again is not far to seek. It lies in an analysis of the procedures accepted as the scientific method both for the prevention of the disease, and its treatment in those cases unfortunate enough to break down with active tuberculosis. As stated above these means are not specific. They are the methods of applied public health. In fact they are so much the scientific practices upon which public health is based that if you enumerate the sections of an adequate sanitary code you can apply them almost sentence for sentence to the treatment of tuberculosis by merely altering the emphasis put upon certain measures. Perhaps a comprehensive definition of tuberculosis work might be stated as the education of the public in the theory and practice of the law as it relates to public health. The educator must be one herself expert in such knowledge.

There are two general types of education, the occasional or didactic and the continuous or tutorial systems. The physician exemplifies the former. His more or less frequent visits should be devoted largely to such education. But the nurse lives with the case. Hers is the tutorial work and its success depends on her proficiency as a wise, patient, sympathetic teacher. It will not do for one with her opportunity to be unversed in the wider fields of public health practice. It is, however, her duty to be especially equipped in a knowledge of the application of these laws to the tuberculosis problem.

AN UNDERSTANDING FELLOWSHIP BETWEEN NURSE AND PATIENT

At this point one must go a step further in considering the philosophy of the nurse in the tuberculosis field. Education in its better sense implies a certain fellowship of minds bent on similar objectives. It is the professor who knows his boys outside the classroom who is remembered after graduation, whose influence is most far-reaching in the educational world. There must be this fellowship, this personal

interest, this understanding friendship on the part of the nurse natively equipped to enter the hard field of tuberculosis work.

"I have eaten your bread and salt,
I have drunk your water and wine.
The deaths ye've died, I have watched beside,
And the lives ye've lived are mine."

True this rule is part of the heritage and the pride of the whole nursing profession, but the real test comes in the maintenance of this attitude over the months and years of association necessary in the field of tuberculosis.

"IT'S DOGGED AS DOES IT"

Social philosophy is difficult of definition. It is one of those intangibles in human relations about which volumes are written but the possession of which is in great measure a gift rather than an acquisition. There are nurses of surpassing skill in certain lines of work but into whose nature this gift does not enter. Their talent may lie in a splendid ability to meet the exigencies of acute disease with their potential emergencies, or in exceptional adroitness in the operating theatre, but they may wholly lack the personal approach, the patient sympathy of the long pull. "It's dogged as does it," quotes Dr. Grenfell in speaking of his beloved Labrador fishermen, and it is certainly the long, hard tug that the nurse engaged in the care of tuberculosis patients needs in her daily, monthly and yearly routine of instruction, encouragement and inspiration to her patients.

Why, then, do nurses need special preparation for this particular field of public health nursing? *First*, we are dealing with a unique disease which makes its own peculiar demands. *Second*, we have no specific cure but must depend on education for its control. *Third*, education can only be promulgated by one who is widely versed in public health practices. *Fourth*, the tutorial system of education alone can penetrate the reluctant public mind. *Fifth*, such education is only possible through the medium of one who possesses a talent for social work in addition to a technical nursing knowledge.

Where social and medical problems mingle so intimately a special human need has been created. That need has found its rational answer in the entrance of the public health nurse into the tuberculosis field.

"Is the day at hand when nurses will need aeroplanes?"

Rural public health nurses have survived the days of walking miles of rural highway and think sometimes that a flivver will take them anywhere. It is not so!

A man from a distant state had deserted his family, leaving a sick child much in need of care. He wrote his wife he had been sick. I located the man at his work—he was a structural worker on a hangar at a new aviation field. In an effort to find out about his character, industry, etc., I had the manager pointed out to me and went to interview him. I walked over hot sand, under a broiling sun, over and around construction material, where not even a Ford could go, and just as I was within a few feet of him, he stopped talking to some men, entered a monoplane and soared out of reach. Is the day at hand when nurses will need aeroplanes?

—From a Pink Sheet Story, Cook County Bureau of Public Welfare, Ohio

Duties of the Nursing Staff in Communicable Disease Service of a Health Department*

By Agnes J. Martin, R.N.

Director, Bureau of Nursing, Department of Health, Syracuse, N. Y.

WHILE the aims of a communicable disease bureau may vary in different communities, the following were named by the chief of this service in the Syracuse Health Department:

Disease prevention
Enforcement of legal requirements
Epidemiological studies and research
Health education
Coöperation with physicians

The aims of a public health nursing service are described by Dr. James Tobey as follows:

> Public health nursing has as its object the saving of life, the upbuilding of family health, and the promotion of community sanitation and hygiene; it deals with individuals and families in its efforts to restore the sick to health, to find and correct physical impairments, and to teach the practice of healthful living and the establishment of hygienic habits.[1]

Public health workers will see much in common in these aims, and the extent of service is limited only by the number of nurses available and the amount of contagion in the community.

The first means of measuring even a minimum of what might be expected in both services is given by the *Appraisal Form* of the American Public Health Association. The score is based on the following points: reporting, case investigation and recording, disease control, visits to cases, diagnostic service, hospitalization and immunization.

At first thought, it would appear that a nursing service had little to do with reporting of communicable diseases, but if the suspicious conditions reported by the nurse and verified by a physician are recorded, it will be found that she plays an important part. This was evidenced by our own experience in an epidemic of measles which extended over 3 years—1926–1928. During that period 8,421 cases were reported, of which 2,187 or 26 per cent were reported by public health nurses, 23 per cent by those of the Department of Health.

In case investigation and recording, the public health nurse is the ideal worker, as the investigation furnishes the observation necessary for adequate quarantine, securing laboratory specimens, advice on hospitalization and immunizations, and a basis for the needed number of follow-up visits. The keeping of spot maps and chronological charts belongs to the communicable disease bureau. They are of great value, however, to the nursing bureau in creating interest and renewed effort in a danger zone.

Importance of Standards

Perhaps the most important factor in the success of a nursing service is the type of nurse employed. The first study made by this section of the American Public Health Association was on qualifications for public health nursing positions.[2] The requirements suggested were progressive in the time element, so are still valuable. Beside the qualifications required for any public health nurse, the moral and social qualities—honesty, faithfulness and dependability—are greatly to be desired. Health departments usually are not free to search the country for this type of worker, frequently being limited by civil service to their particular communities. Their staffs are likely to have some nurses, both old in training and in years, appointed before standards were considered important. Many of these have grown profession-

* Read before the Public Health Nursing Section of the American Public Health Association at the Annual Meeting, Minneapolis, Minn., October 4, 1929.

ally through valuable experience and personal development, while others have plodded along satisfied with the status quo. It therefore becomes the duty of the department or bureau to carry on a continuous educational program on the newer methods of treatment and control of communicable diseases.

ESSENTIAL INFORMATION

What are some of the important things the public health nurse should know?

The nurse should know how to teach personal and home hygiene.

The community that furnishes instruction in personal and home hygiene is building its strongest defense against communicable diseases. Diet, rest, exercise, cleanliness, good habits of eating, sleeping and working, care of food, sanitation and ventilation of the home, furnish subjects for home visits and group instruction. It is, however, another matter to bring into actual use such practices as washing the hands before and after handling food, and after using the toilet; avoiding the common drinking cup or towel; and covering the mouth in coughing or sneezing. Thus to improve living conditions requires the utmost tact, patience and perseverance of the worker. It is too obvious to suggest that the nurse herself should be the exponent of this teaching, also that she protect herself through annual physical examinations and such immunizations as the service demands.

The nurse should be familiar with the Sanitary Code of the state and city.

There is considerable variation in the codes of various states and even some in various communities of the same state. The community code, however, may not be less stringent than that of the state department of health. A glimpse at the variations noted in the chapter on "Control of Communicable Diseases," in *Public Health Bulletin 164*, is most convincing on this point.[8]

The nurse should know the symptoms, periods of incubation and isolation, and approved methods of treatment of all common communicable diseases.

Knowledge of symptoms is important as nurses calling in the home on other errands are frequently the first consulted on suspicious conditions. A card diagram giving such data as period of quarantine for patient and non-immunes, as well as other contacts in all of the common contagions, is provided by many states and serves as a helpful reminder.

Exception might be taken to the suggestion that the nurse should be informed on approved methods of treatment. The inference that from such knowledge the nurse might proceed to advise treatment and thus invade the province of the physician is of course obvious. Since a large number of families unfortunately never call a doctor, it is very much of a question whether medical advice by the nurse is not justified. Superstitions and unscientific home remedies are all too common and must be combated by urging the acceptance of modern scientific methods.

The nurse should be familiar with the nature of the various infectious diseases and their mode of transmission.

For teaching methods of control this information is indispensable since most diseases are transmitted through personal contact, direct or indirect. The nurse must know how they may be transferred through contact, food, insects, and inoculation.

METHODS OF CONTROL

Above all, the nurse should know methods of control through: Recognition and report, Isolation of patient, Quarantine, Disinfection, and Immunization.

Recognition and Report

This requirement again emphasizes the importance of recognizing, especially, early symptoms. New York State puts the responsibility of reporting on the head of a private household or the person in charge of any institu-

tion, school, hotel, boarding house, etc. The physician, if present, bears the responsibility for instructing the family in precautions until a representative of the local health department calls. Many of the larger cities employ a diagnostician to verify major and rare contagions, after which the supervision is passed on to the nurse. When an epidemiological card is used it affords an easy and natural means of entrance into the home, and of securing helpful data on source of infection, contacts exposed, and possibilities of quarantine arrangements. When accurately obtained, these data serve as the basis for scientific studies which may add to the knowledge of disease and influence policies for its better control.

Isolation

In the case of a large family, crowded conditions, institutions, hotel, or boarding house, isolation is secured only through hospitalization. This is obtained in coöperation with the family physician or through action of the health officer. The sanitary code usually provides the necessary legal authority to enforce hospitalization if such facilities are available. It is interesting to note from the Report of the Committee on the Relation of Health Departments and Hospitals that health departments are utilizing general hospitals in many communities, the city paying for indigent cases on a per diem basis.[5] However, there will always be instances in every community needing care where no hospital facilities are available, in which case health departments should utilize the visiting nurse. From a review of a number of annual reports of visiting nurse services, it would seem that this custom is increasing; one report showed 14 per cent of all calls made were on communicable diseases. *Public Health Bulletin 164* states that in 1924 many cities did not advise concurrent disinfection except where visiting nurses were permitted to give bedside care.[6]

It is the duty of the official public health nurse to teach the mother, or other adult assuming responsibility for the care of the patient, the technic involved. The demonstration method is preferred, Pillsbury pointed out that any prophylactic technic to be successfully carried out must (1) appeal to reason, (2) be simple, (3) be adaptable, (4) be economical of time and money, (5) be understood in order for it to be effectively practiced and taught.[7]

Quarantine

The tendency today is to make quarantine more lenient, especially as it affects contacts. New York's code was markedly changed in this direction last July. If the understanding and coöperation of the public are secured, it will lessen the hardships imposed. The American Public Health Association *Appraisal Form* gives a minimum standard of home visits believed necessary for each disease during the period of quarantine.[8] The public health nurse makes the ideal quarantine visitor—her example in technic cannot fail to make an impression on the mother, especially when explained in simple and readily understood terms. When quarantine is broken her understanding of housekeeping, added to her technical knowledge, helps to make individual adjustments more readily than is possible for one without this training.

Disinfection

In teaching disinfection, it is important to know the location of the disease germs, and when and how to destroy them. Most germs are found in the discharges from the body. The daily care of this material as it is discharged is called concurrent disinfection, and instruction for its safe disposal must be very definite as to methods.

For the final or terminal disinfection, instructions are given for the clean-up of the patient and quarters. Most nurses can advise on the bath and shampoo but when it comes to the patient's room they still think fre-

quently of fumigation when all that is required is thorough scrubbing with soap and water, plenty of air and sunlight. The length of time of exposure to sun and air depends on the strength of the sun's rays. Freezing should not be depended upon to destroy germs.

Immunization

Here especially is it necessary for the public health nurse to know the newest practices regarding control and treatment. She does not, of course, advise on treatment in the presence of disease if a doctor is in attendance but it is important that she know of the various vaccines, serums and antitoxins to intelligently answer questions, and urge immunization.

GENERALIZED SERVICE

There is just one other thing that the writer would urge for an adequate alliance between a nursing bureau and all other bureaus requiring nursing services, and that is the adoption of the generalized form of nursing. True, the nurse under this system may lack highly specialized technic, but her broader understanding more than offsets this handicap and she usually enjoys a greater confidence of the people of her district. Furthermore, the ability to swing a large group of experienced workers into the contagious field in the face of an epidemic, or mobilize this group for any other special need, is no minor argument.

Besides all this, the nurse functioning in a generalized plan has an opportunity to arrange for the maintenance of the health of a family without the confusion which is apt to arise when two or more advisers consult with the mother. Trying to meet all the health and social problems arising in a family is a challenge to the alert nurse, and offers an opportunity to do constructive work of the highest order.

The same set of nurses are on duty at all clinics and health conferences, and follow the children through the school health program. They inspect and supervise child boarding homes. With their knowledge of a family's health and social needs well defined, the generalized nurse does less transferring of information, with less opportunity for confusion in the home.

SUMMARY

The responsibilities and opportunities of a communicable disease nursing service in a health department should be—

Teaching personal and home hygiene to the family as a unit.
Recognition and reporting of probable communicable disease.
Establishment, supervision, and release of quarantine.
Propagandizing of accepted immunization procedure.
Securing adequate nursing care.

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When stockings "ladder" where do they run? They run "down north on the Labrador" and become hooked rugs.

Discarded silk or artificial silk stockings and underwear, no matter how old and worn, are wanted by the Industrial Director, International Grenfell Association, St. Anthony, Newfoundland. Cut off the tops and feet of the stockings so as to save postage.

A Health Program for Community and Industry

By Belle Fuller, R.N.
Pacolet Manufacturing Company, Pacolet, S. C.

THE health work at Pacolet Mills started from a very small beginning. In 1916 a nurse was hired. She was the first industrial nurse in this part of the country, and was therefore quite a curiosity in the community. Coming from the north and having had no experience in cotton mill communities it was rather an adventure on her part.

Today we have a health center, centrally located, with three nurses, a dentist and a physician. We have ten available beds, and ten cribs for hospital use. We have a good operating room and sterilizing plant, pleasant offices and waiting rooms for the doctor and dentist, and treatment room and offices for the nurses. We also have a large sunny clinic and lecture room.

HEALTH PROGRAM

Every operative is given a free physical examination once a year and oftener if his condition warrants it. Each new applicant for work must have a physical examination before he is employed.

All the first aid work is done by the nurses and this service is free to employes. No charge is made for hospital care of employes but they pay their own doctor's bill and buy their own medicine. We do all of our minor surgery here, but the major surgery is sent in to the County Hospital.

We visit in the village and give bedside care wherever it is needed. The first aid room is open all day long, and a nurse accompanies the doctor on all deliveries.

Three regular clinics are held each week. On Monday we have a baby clinic, on Tuesday a clinic for school children and on Wednesday a prenatal clinic.

We find that since we have a well rounded health program we have a great deal less sickness in the village, and noticeably less contagious diseases, and very little sickness among our babies.

Our prenatal work has been of untold value, and the instruction given the expectant mothers has been of wonderful help to them, both before and after delivery.

The school children are sent from the school in groups accompanied by a teacher. They are checked up as far as possible by the nurses. Any who need special attention are sent to the doctor who makes these examinations on clinic days free of charge. The undernourished children are weighed regularly and special attention given to diet and correction of defects. Four were sent to a health camp during vacation. Each school day at 9 o'clock a list of all absent children is sent from the school to the health center and each child absent is visited by a nurse before noon and a report on each is sent back to the school by 2 o'clock.

The school and health center work together in trying to correct defects in children and in getting vaccinations completed.

PRESCHOOL EXAMINATIONS

After school closed this spring the teachers made a survey of the village checking all children who would enter school for the first time this fall. This list they sent in to the health center and the nurses visited the parents of these children urging that they have the children vaccinated and defects corrected before entering school. The result was that by August 1st every child was vaccinated, several had tonsil operations and some had dental work done. This work will be taken up again at the beginning of the school year.

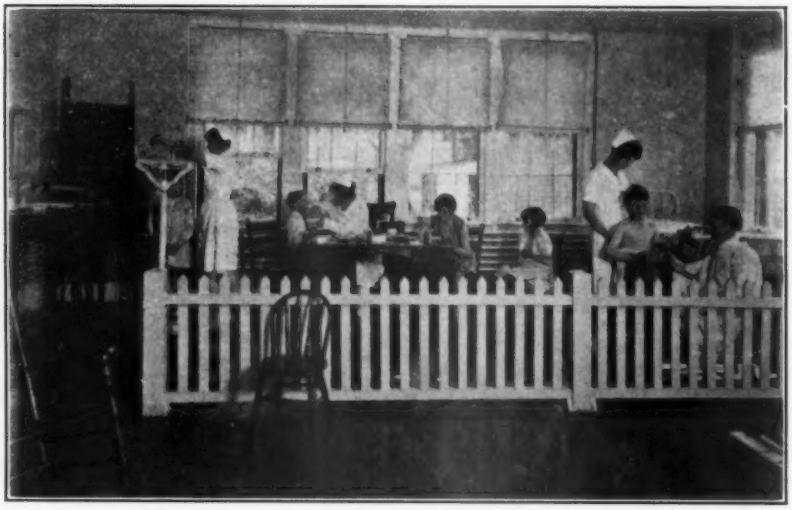
CLASSES AND GARDENS

In addition to this work several classes are taught each year. We teach Home Hygiene and Care of the Sick,

for girls and women, and first aid for all the groups. We have just completed a course in junior first aid for the Boy Scouts. We have also had most interesting classes in bedside nursing and first aid for the colored people in our community.

PELLAGRA PREVENTION PROGRAM

The doctor in charge of our County Health Unit asked us to put on a Pellagra Prevention Campaign during the month of March.



At the School Clinic

He was invited to meet with the Community Service Council and present the matter to them. He gave a most interesting and instructive talk, speaking of the increasing number of pellagra patients in our county, emphasizing the fact that it is preventable and also curable, and urging that we put on an intensive educational program. The Council voted to do this and appointed a committee to take the matter in hand.

During the chapel period the school children were told the importance of eating the right foods to make them grow strong and keep well, and the project of growing a kitchen garden of their own was outlined to them. Following the talk the superintendent of the school made the announcement that, if the children wanted to compete in gardening, the school would offer a prize for the best garden and the nurses would act as judges.

The next week the representative of the County Home Demonstration Bureau talked to the school children, telling them how to start their gardens, the vegetables to plant, time of planting, etc. The school children were very enthusiastic about having their own gardens and over two hundred announced their intention of competing in the contest. The Community Service Council agreed to make an appropriation to buy seeds for the school children so that each child should have the same variety and quantity of seed.

Twelve posters were made by the school children and nurses showing the foods that constitute a wholesome diet, and each poster carried some wording about pellagra prevention. They were then posted in prominent positions in the village. Each teacher in the school used the county bulletin on pellagra in teaching health lessons in the grades, and food study was made a special

theme in the Girl Scout troups during the month.

One church used the morning service for a health program. Three nurses in Red Cross uniforms were on the platform and one talked on pellagra. When the foods for its prevention were named, children came up the aisles carrying baskets containing the approved fruits and vegetables and milk products.

cured and a copy sent by the Boy Scouts to each family in the village. A supply of Brewer's Yeast was also ordered from the State Board of Health to use in Nutrition work.

In May all the school gardens were inspected. Children living in the village had better gardens than the children living in the country, although these country children had the same privilege as the mill children.

Lining up for the Nurse

It was interesting to note that most of the green vegetables presented were grown in the village, and even as early in the season as this they had carrots, cabbage, lettuce, spinach, onions and potatoes. A copy of the County Bulletin was given to each adult at this service.

During the month a public mass meeting with over 500 people present was held in the Community building. We advertised the meeting by sending out to each family in the village by the Girl Scouts a bulletin on pellagra issued by an insurance company. The cover of this bulletin carried the announcement of the mass meeting, subject and speakers.

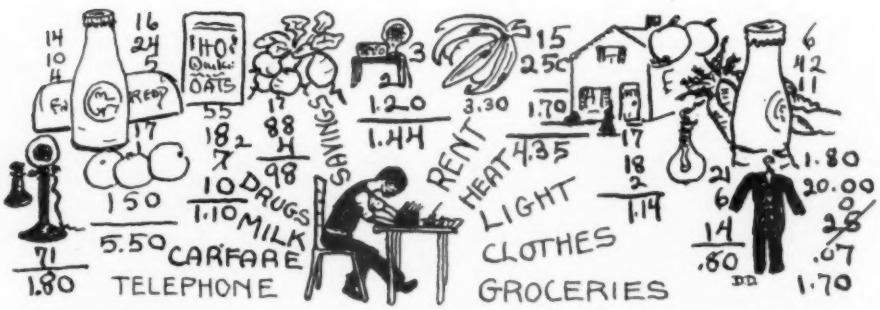
A Clemson College bulletin on Home Gardening in South Carolina was pro-

Most of the children had very good gardens. The visiting nurses first inspected all gardens and then checked the ones they considered the best, about thirty gardens out of more than two hundred. Then a nurse and the landscape gardener visited the ones checked and selected the best out of this group.

A small girl eleven years old had the best garden of all, and second place was won by a boy of eleven years. The parents said that the children did all the work on the gardens themselves. We found the parents as keenly interested in gardening as the children and most homes had fine kitchen gardens, a good variety of vegetables, clean and well cared for. We have had less pellagra this year than in four previous years, so our campaign did help.

Budgeting the Family Income

By Blanche Dimond
Nutrition Supervisor, Community Health Association, Boston, Mass.



IN the November, 1926, issue of The Public Health Nurse Miss Ada Moser, then Nutrition Supervisor of the Boston Community Health Association, outlined very comprehensively the nutrition program of the Community Health Association. The purpose of this article is to describe only one particular phase of the work, but the following summary may be helpful to those who did not read Miss Moser's article.

The Community Health Association has a staff of seven nutritionists, six field workers and a supervisor, who divide their time among fourteen district offices of the organization. Their work is twofold, to do nutrition teaching themselves and to stimulate the nurses to do it. As the staff of the Community Health Association visits one thousand cases daily, it is obvious that seven nutritionists can reach but a small percentage of these patients. Consequently, much of this teaching is done by the staff nurses.

TEACHING THE STAFF

To assume their rôle of teachers, the nurses take informal courses consisting of lectures given by the nutrition supervisor, and conferences—both station and individual—with the nutritionist. The nurses do most of the routine teaching of the patients, referring only difficult cases to the nutritionist for intensive work. It is evident that the contact between nurse and nutritionist is very close and must be in order to have the best results. Practically all of the cases which the nutritionist carries, except those referred by outside agencies, are called to her attention by the nurses and turned back to them when the nutritionist's visits are over. By following this plan the nutritionist is used largely as a teacher and consultant for the following types of cases: prenatal, convalescent, special diet, family, budget, and children. Each nutritionist also attends two Mothers' Clubs, classes given weekly for expectant mothers, at which the nutritionist talks on some phase of nutrition, advises the women individually regarding their diet, and demonstrates suitable food. The "Book of Etiquette" may not consider creamed cabbage sufficiently dainty for afternoon party refreshments, but it serves a purpose, for many women have been persuaded to serve it at home after they have tried it at Mothers' Club.

The nutrition supervisor gives lectures to the new staff nurses, prepares teaching material, does some visiting in the field, and supervises the other nutritionists. Such is the general

nutrition program of the Community Health Association.

BUDGETING

The purpose of this article is to describe one of the important features of the nutrition program — the budget work. This was formerly performed by the Dietetic Bureau which went out of existence in 1923.

As a basis for budget work the nutritionists twice yearly make up a schedule for low-income families. This schedule is available to other agencies and is used by most of the private and many of the public relief-giving agencies in the city and state. At the present time the figures are sent to seventy-five agencies and private individuals.

These figures are put to many interesting uses. By referring to them several out-patient departments of hospitals decide whether a patient shall have free admission or not, while others determine from them the weekly charges to their patients. Our own agency and some relief agencies use them in deciding whether a family income is adequate or needs to be supplemented.

The budget figures are carefully computed from prices collected by our nutrition staff in different sections of Boston. Food prices are an average of those at the chain store and the little corner grocery store where so many of the women trade because there they may run accounts. The clothing figures are averaged from seven or eight of the bargain basement stores or those selling the cheaper type of merchandise. The fuel figures are also obtained in the neighborhood stores.

Besides getting out the budget figures our nutritionists do much home visiting on budget cases, both for our own and for other organizations. Here they help the woman, sometimes the man, distribute the family income, planning for each item of the budget. They advise how to spend the food money, suggesting grocery orders, menus, and help in marketing. Such agencies as the Family Welfare Society, Mothers' Aid, and the Overseers of Public Welfare frequently request budget supervision for their families.

A budget case successfully carried to its conclusion is one of the most satisfying experiences of a nutritionist. To get a family out of debt, show a mother how to spend her money for well-balanced, economical meals, durable and suitable clothing, and meet all other necessary expenses so that they are buying health instead of sickness and acquiring a sense of self-respect is one of the biggest contributions a nutritionist can make.

REQUIREMENTS FOR SUCCESSFUL BUDGETING

Several requirements are necessary for the most successful family budget work. The income should be adequate according to minimum standards, or some provision should be made for supplementing it. The woman or some one responsible for spending the family income must be intelligent enough to follow directions. Last, but very important, the family must be interested and eager for help in adjusting their income to meet the demands upon it. This interest can be stimulated by the right kind of nurse or nutritionist. She must have enthusiasm herself before she can sell the budget services to the family.

The possibilities of budget work are shown by the following case, which is also interesting because all of our services with the exception of the orthopedic were used by the family at different periods. In other words, they were given bedside nursing service and prenatal care, mental health and nutrition service.

A BUDGET CASE

Walter Jones was sick, or had convinced his mother that he was not well enough to go to school. Mrs. Jones was so worried that she called one of our nurses to care for Walter. On the first visit Miss Gates found the house dirty and untidy; the patient, Walter, a stubborn, whining, domineering child of seven years, oldest of three, in a temper tantrum; the mother, pregnant, worried and discouraged over her condition, the bad behavior of the children

and the unsatisfactory financial outlook. She and her husband had contracted innumerable bills, although he was a model provider and had been out of work only once since their marriage and then only because of a broken leg. Miss Gates gave nursing care to Walter, admitted Mrs. Jones as a prenatal patient, listened to the recital of her woes, and suggested that a nutritionist might help her get out of debt.

When Miss Hill, the nutritionist, first visited the home, she found Mrs. Jones hunting in all sorts of odd places for her bills and receipts which she had promised to have ready—under a mattress, behind pictures, and in bureau drawers. She was very glad to see Miss Hill and seemed anxious for help. She had apparently made some effort to clean the house, and the children were at her mother-in-law's for the day; as Mrs. Jones said, "She don't often offer to take 'em, so believe me, I let her—so anyway, the house is quiet, and Jim, my husband, is going to try to get back before you leave."

"WHAT A BUDGET DOES FOR YOU"

Miss Hill and Mrs. Jones together worked out a minimum weekly budget of $25.50, allowing $12.00 for food, $6.25 for rent, $2.25 for fuel, with the rest for the other items of the budget. That left a balance of $12.00 to apply on the bills. It seemed a huge amount to Mrs. Jones, but she said, "I suppose that's what a budget does for you."

Next they checked the bills, a long process as Mrs. Jones kept thinking of additional ones—$6.00 to a pedlar for crib sheets, $18.00 to a loan association, and so it went. One rather unnecessary bill, or so it seemed to Miss Hill, was $150.00 for a radio, but Mrs. Jones gave a delightfully illogical explanation: "Jim decided to work nights to catch up on our back bills, and thought I'd be lonesome and a radio would keep me company."

Mr. Jones came in time to have the budget explained to him. He, too, seemed very discouraged, but anxious to try anything that might help. He seemed more capable of managing the family finances than his wife, and agreed to be responsible for spending the money and keeping the accounts.

Miss Hill suggested that with the $12.00 allowed for food Mrs. Jones get 4 quarts of milk and divide the rest of the money in this way: $2.45 for vegetables and fruit, the same amount for meat, fish and eggs, $2.00 for bread and cereal, and $1.80 for miscellaneous groceries. After she told them why they needed so much milk, vegetables, and fruit, they were willing to try the new plan, although for them it was a radical departure. Mrs. Jones had always bought much meat, little milk, and few vegetables.

She followed suggestions and recipes given her for using cheaper cuts of meat, ways of cooking milk and vegetable dishes. The family actually learned to enjoy beef stew, meat loaf, chowders, puddings and many other economical dishes rather than the chops and steaks to which they were accustomed. Mrs. Jones drastically reduced her food bills, yet at the same time the family was better nourished. Her enthusiasm made her an excellent publicity worker, for she went about the neighborhood informing every one that she was "on a budget," her tone implying that it was a superior kind of spring tonic. One day she said to Miss Hill, "Mrs. Jenks upstairs wanted to borrow my budget, but I told her that every one was different and maybe you'd go to see her some day." Mrs. Jones was not even resentful when Mr. Jones told her relatives not to come to the house so often for meals, because she wanted to keep down the cost of food!

The children were visited by a mental health worker from our organization who suggested the Habit Clinic for Walter. After going to clinic, he improved greatly, soon getting over his temper tantrums so that Mrs. Jones had more time to devote to her housework and Mr. Jones was able to rest better at night.

THE REWARD OF EFFORT

That the family did so well was largely due to the efforts of Mr. Jones, a really unusual man. He encouraged

WEEKLY RECORD FOR FOOD

COMMUNITY HEALTH ASSOCIATION
NUTRITION SERVICE, BOSTON, MASS.

Name Address Date

MILK, CHEESE, CREAM Contain the best growth material for children	cost	MEAT, FISH, EGGS Good muscle building material	cost	VEGETABLES AND FRUITS Minerals and Vitamins Also bulk to prevent constipation	cost	BREAD, CEREALS, FLOUR, RICE MACARONI, CAKE Good building materials Fuel for the body engine	cost	SUGAR, FATS, TEA, COFFEE OTHER GROCERIES Fuel for the body engine	cost
Total		Total		Total		Total		Total	
At least 1½ pints of Milk for each child and 1½ cups of Milk for each adult daily		Buy inexpensive cuts of Meat		Spend at least as much for vegetables and fruit as for meat, fish and eggs		About ⅓ of total cost Buy whole grain cereals and breads often		About 15 to 18% of the total cost	

his wife to follow the directions of Miss Hill and kept all accounts himself. Although it seems impossible, he actually helped his wife make over an old coat for herself in his determination to run no more bills. Miss Hill had suggested that Mr. Jones buy a tin box for holding bills and receipts and that on pay days he divide his money into envelopes for the different items of the budget—rent, food, etc. Anyone who has ever tried to budget a family can well imagine what a thrilling experience she had when one day she paid an unexpected visit to the Joneses. Mr. Jones, his sleeves rolled up and an anxious frown wrinkling his forehead, was seated at a table with his box, envelopes and account book, wrestling with his finances.

They followed their budget almost exactly, reduced their debts according to schedule, bought some clothing and equipment for which they actually paid cash. The housekeeping, meal planning, cooking and the behavior of the children all showed marked improvement at the time of discharge and Mr. Jones had received a raise of $1.50 a week which they were putting in the bank.

This case was an outstanding success, and it is interesting to note that the three factors which were suggested as necessary for the best results in budget work were all present in this case. The income was adequate according to minimum standards, the person responsible for spending the family income was intelligent, and the family was eager and ready for help.

WEEKLY INCOME

Money on hand at beginning of week	$.....	
Money earned or received during week	$.....	
.....	$.....	
.....	$.....	
Total	$.....	$.....

WEEKLY EXPENDITURES

	(AMOUNT)	
Food in the home (see other other side).....	$.....	
Lunches.....	$.....	
Clothing and personal equipment		
.....	$.....	
.....	$.....	
.....	$.....	
.....	$.....	
.....	$.....	
		$.....
Rent (or cost of house ownership).....	$.....	
Fuel and Light		
Coal.....	$.....	
Gas.....	$.....	
Electricity.....	$.....	
Wood.....	$.....	
Kerosene.....	$.....	
		$.....
Household equipment and supplies		
.....	$.....	
.....	$.....	
.....	$.....	
.....	$.....	
		$.....
Carfare ....., ..., ..., ..., ..., ..., ...,		
		$.....
Health (doctor, dentist, medicine).....	$.....	
Church, School, Recreation		
.....	$.....	
.....	$.....	
.....	$.....	
		$.....
Insurance.....	$.....	
Other Expenses (including savings)		
.....	$.....	
.....	$.....	
.....	$.....	
		$.....
Total Amount spent during week	$.....	
Money left over at end of week.....	$.....	$.....

A Unified County Public Health Nursing Service

By Virginia A. Jones
Director, Public Health Nursing Service, Richmond, Indiana

WAYS and means of guarding the health of a community have for some time been recognized as a necessity for our comfort and happiness. Consequently, few counties in Indiana are without some form of public health activity. The fact, however, which has not always been recognized is, that to guard the community health effectively, it takes not only "coöperation from every livin' soul" but also the organized unified effort of all agencies carrying on any form of public work.

Indiana, as well as other states, is unfortunate in that it does not have any legislation which provides for a full time county health officer. This makes it necessary for the initial attempts at unification to depend upon the efforts of the private non-official agencies to a large extent. Many times this effort is left almost entirely to the public health nursing group in the community.

THE RURAL PROBLEM OF ORGANIZATION

If the county has only a very small city population, the organization problem is not so difficult, for the one nurse is truly a county-wide nurse, making not agency contacts but individual ones with health officer, physicians, lay groups, etc.

If, however, one or more large cities exist within the boundaries they have more or less complicated organizations, including health officers, school physicians, school nurses, tuberculosis nurses, visiting nurses, etc. Perhaps one lone nurse with a health officer—who, because of insufficient pay, has very little time to spare for public health—is struggling along in the rural part of the county, trying in vain to put on a well-rounded public health program, envying the city nurses their opportunities for fellowship, self-improvement and aid from trained supervisors.

Why shouldn't the one nurse and the health officer in the rural district have the advantage of the help of the competent city public health staff?

There has been just a beginning made in this respect in Wayne County, Indiana, within the last three years. The county includes Richmond, a growing city of 30,000 and about 20,000 population outside the city with quite a few small towns.

The history of most welfare movements, including public health, shows that private unofficial groups see and meet community needs first, then after a period of demonstration, are relieved of the responsibility by official agencies where this responsibility rightfully rests.

In Richmond, before visiting nursing was made a part of the public health program the County Chapter of the Red Cross, the County Tuberculosis Committee and the City Welfare Society were already under the direction of one executive, a social worker. Then the visiting nursing agency entered to emphasize the health side of social service. Jointly financed by the welfare society and by the City School Board, the city services were added. About this time the Metropolitan Life Insurance Company entered into contract with the nursing agency to care for its policy holders on a fee basis. Three staff nurses and a director carried on a generalized nursing service in the city.

THE CITY REMEMBERS THE COUNTY

Soon, Richmond, realizing that a county is only as healthy as its most unhealthy part, set about to develop rural nursing. Again the private agencies came to the rescue. A full time Red Cross nurse and two part time nurses, financed by the County Tuberculosis Committee, followed each other in county nursing for three con-

secutive years, all of them working from the same headquarters as the city nurses. During this time the City and County councils found it wise, by means of an appropriation to the Health Officer, to support and furnish nursing follow-up for a county venereal disease clinic, which had previously been supported in part by the private agency. This clinic is under the direction of a committee headed by the City and County Health Officers. Another project had been taken over by its rightful owner, the official organization.

GRADUAL JOINT SUPPORT

Three years ago, the County Board of Education, realizing, at last, that nursing service was valuable in its rural schools, employed a full time nurse. Her transportation is furnished by the County Tuberculosis Committee, in return for which the nurse conducts the Modern Health Crusade in the schools and does tuberculosis nursing. Recognizing the many advantages of having the county nurse aided in planning a well-founded public health nursing program, arrangements were made to have the city nursing supervisor direct the work, with the hope that mutual advantage to the nurse and to the county would result through association and conferences with the city staff.

The work of the whole county was then financed jointly by three non-official agencies, the County Tuberculosis Committee, the City Welfare Society and the Metropolitan Life Insurance Company, and by three official agencies, the City School Board, the County Board of Education and the City and County Councils.

DIRECTION OF THE WORK

The public health work is directed by a committee made up of representatives from each of these agencies, the city and county health officers representing the city and county Councils. Representatives from other interested agencies, the Medical Association and the public at large complete the governing body of the county-wide Public Health Nursing Service. This arrangement is only possible because the financing agencies have unified the service by vesting the power of its direction in one well trained nursing supervisor who is responsible for organizing the service, planning the programs, including staff education and field supervision and for developing the work throughout the county.

An attempt to have the nursing outside the city taken over by the County Council is almost completed. This would obliterate the township lines and leave no excuse for certain townships to refuse the service. Such a plan is legal because a health officer can ask for any reasonable funds for the suppression and control of communicable diseases to a certain limit. This would bring the nursing under the direction of the part time county health commissioner, instead of under the Board of Education, which is made up of the township trustees and the county superintendent of schools.

ADVANTAGES OF FINANCING BY COUNTY COUNCIL

We see in this plan several advantages:

The erasing of township lines, making it unnecessary for the nurse to carefully divide her time among the townships according to the amount of money paid instead of according to the needs found.

The nurse would not be limited to school work alone, but could carry on a generalized program.

The present method of each trustee paying small monthly amounts at irregular times would be abolished.

The work would be directed by the Health Commissioner and supervised by a trained public health nurse. It makes it possible for the county nurse to have supervision, observation, and aid in planning and working out a generalized program to fit the needs of the people.

It makes the health program a definite unit for the whole county instead of allowing distinct division lines between urban and rural population, whose needs are practically the same.

The work now embraces all age groups and types of work in a general-

ized public health nursing service. It includes the supervision and instruction in care of prenatal cases and babies, preschool round-ups and examinations, supervision of school children, nursing care to the sick in their homes, work in the control of communicable diseases, county clinics for the care of the tuberculous and venereal diseases and follow-up by the nurse, and participation in all efforts towards raising community health standards. The county nursing has, because of its methods of financing, been necessarily limited to tuberculosis work, supervision of preschool and school children, efforts in control of communicable diseases, educational work in 4H clubs and venereal disease follow-up.

A FUTURE GOAL

The plan for the future is to secure for the rural district:

The same health measures that have been essential in the city; namely, suitable sanitary arrangements, adequate medical and nursing service in times of illness, opportunities for early diagnosis and treatment of disease, health education and physical examination of school children, skilled oversight of babies and a type of health instruction that will make all these things desired.

This is best done under a well prepared full time County Health Officer with competent nursing supervisor and staff, all supported by the county official agency, the County Council. The coöperative arrangement of County Tuberculosis Committee and the Metropolitan Life Insurance Company should still exist to supplement the work of the official agency and to try out new projects for which the official agency might have no funds.

Such a plan is entirely possible and shows promise of solving many of the problems involved in county nursing.

From *Habit Training for Children*, a simple, direct statement prepared by the Massachusetts Society for Mental Hygiene, we quote the following on teaching children correct toilet habits:

Things to Do

Make up your mind that the habit of wetting can be overcome.
Gain the child's interest in stopping it.
Tell him he is going to overcome it.
Make him understand that it is his business to cure himself, but that you will help him.
Follow these directions *regularly* and *faithfully:*
- Supper at a regular time.
- Nothing to eat or drink after supper.
- Toilet at bed time.
- Awake him fully later in the evening, always at the same hour, and have him go to the toilet.
- Further directions to be given by the doctor.

Give more time to training and less to making excuses.
Make much of every gain, however small it may be.
Look forward to success.

Things to Avoid

Don't take the habit as something that cannot be corrected.
Don't make him feel he cannot help it.
Don't discourage him in any way.
Don't make the excuse of sickness when he is really well.
Don't make the child feel ashamed.
Don't talk about the habit to every one.

Remember

Children like praise.
They are more sensitive to what you feel than to what you say.
They like to do what is expected of them.
You will get about what you expect.
Expect the best.

Copies of this leaflet are available at ten cents a copy or $3.00 per hundred.

Physiological Management of Children Handicapped by Cerebral Palsy *

By Bronson Crothers, M.D.
Harvard Medical School and Children's Hospital, Boston, Mass.

THE group of disorders which are included under cerebral palsy are regarded by most doctors and nurses with pessimism, and treatment is either not undertaken at all or is undertaken rather gloomily. The pessimists justify their attitude by arguing that repair of brain tissue is almost negligible and that, on the whole, mental defect is so usual that education is hardly worth while. All of us know that the only efficient nurses, teachers or doctors are those who look upon the children under their charge with optimism and with curiosity. I am quite convinced that there is no reason why children with cerebral palsy should not be so regarded.

Everyone except a few trained neurologists and physiologists regards the brain as a very complicated organ, so complicated in fact that it can hardly be discussed at all. In self defense other groups of practitioners have worked out rather unduly simple diagrams. However, I think a profitable idea of the control of motion can be gained without great difficulty or unreasonable inaccuracy.

The muscle fibre contracts when impulses are propagated from the motor cell in the spinal cord along a nerve fibre to the muscle fibre. This contraction of the muscle fibre is always the same whatever the character of the stimulus which provokes it. The actual motor response, visible as muscle contraction, of course depends upon many fibres and its vigor and persistence may vary enormously.

When the relatively simple mechanism consisting of muscle fibre, nerve fibre and anterior horn cell is damaged there follows abolition of function or flaccid paralysis of the muscle fibre concerned. This happens in infantile paralysis, for example. The therapeutic problem is theoretically quite simple. A certain number of units have been subtracted and those that remain must be utilized to best advantage. The relatively complicated measures used in solving this simple theoretical problem bear witness to the ingenuity and the optimism of the orthopedic surgeon in utilizing remaining assets.

When disease or injury interferes with the motor part of the nervous system above the final apparatus consisting of anterior horn cell, nerve fibre and muscle fibre, perversion of control rather than abolition of function occurs.

Although the ensuing problem no longer involves mere subtraction there is, I think, no reason to refuse to attempt to discover and utilize the physiological residue. Obviously a simple but reasonably sound idea of the general anatomical and physiological situation is essential.

On the whole, the children who form the group of cerebral palsies are not suffering from progressive disease, nor are they likely to deteriorate. Usually a blow, either from hæmorrhage or infection, has been inflicted, leaving the nervous system damaged. The pessimists are probably nearly correct in stating that repair is negligible, but there is no justification for refusing to expect adaptation and return of function as a result.

Several points must be constantly borne in mind. By far the most essential is to remember that motor disturbance and mental disturbance are entirely distinct affairs. Absolute idiocy may exist without motor incompetence and complete disorganization

* A 1929 Edith Butler Pool Lecture presented before the Staff of The Visiting Nurse Association of Chicago, Tuesday, June 11, 1929. Reprinted by courtesy of the author and The Visiting Nurse Association of Chicago.

of the motor control may exist in a child with intact intelligence. A logical diagnosis must include statements as to intellectual as well as motor assets. Only such a diagnosis allows the one in charge to establish a promising educational program.

The motor control is relatively simple, and can be expressed diagrammatically. The final apparatus, so often damaged by infantile paralysis or by nerve or spinal cord injury, can be exactly examined and adequately treated. The disability is the result of subtraction of a variable number of units.

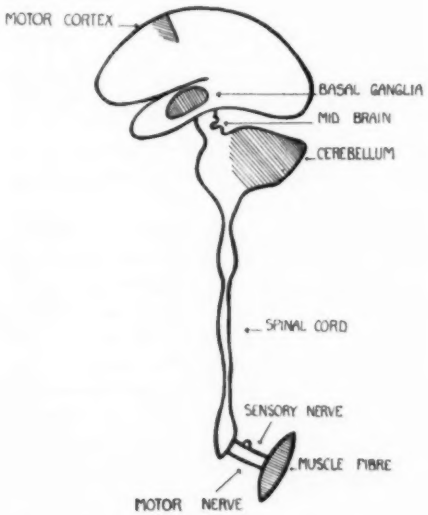


Figure I. General plan of central nervous system showing relatively small bulk of tissue containing cells which directly control motion.

The control of these final units, however, is less simple. It is, however, possible to divide the problem into manageable units. The first obvious possibility is that perfectly accurate motor impulses may be misdirected because the information from the muscles, through sensory paths is defective or lacking. This happens typically in locomotor ataxia. An even more disabling situation arises when impulses of all sorts are confused by more or less serious injury of the whole spinal cord.

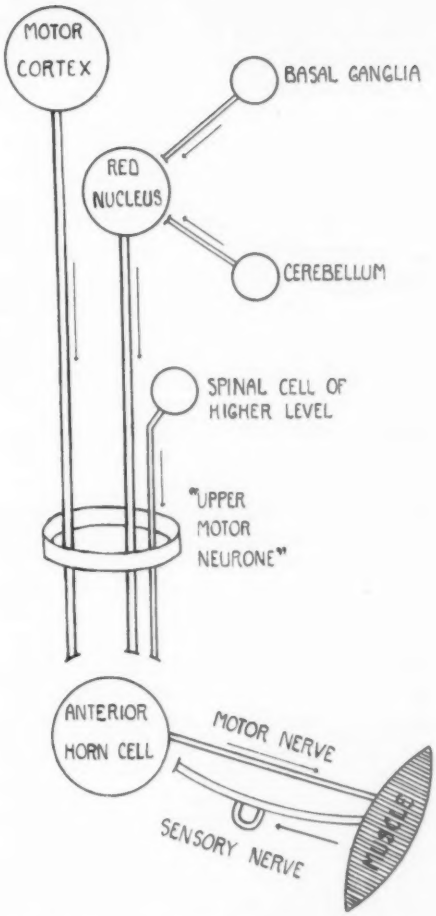


Figure II. The more important groups of cells controlling motion. The "upper motor neurone" consists of bundles of fibers from various levels.

Granted, however, that the final apparatus is intact and that the pathways through the spinal cord are intact, four main types of disturbance can be caused by injury of the brain itself.

MAIN TYPES OF DISTURBANCE

1. *Cerebellum.* The cerebellum may be injured, in which case confusion of motion results from the failure of muscles to work smoothly together. The term asynergia is technically used for this condition. Nystagmus, unsteady gait and rather atonic muscles are frequent symptoms. The cerebellar lesions are relatively infrequent and

the possibility of progressive disease is so great that sustained medical interest is usually aroused.

2. *Basal Ganglia* (Caudate and Lenticular Nuclei). Above the cerebellum, deep in the substance of the cerebral hemispheres lie cell masses whose function is extremely important. The control of orderly associated movements of primitive type is apparently central in the caudate and lenticular nuclei. Disorders of two types are caused by lesions here. In certain cases, tremulous rigidity of the type seen in paralysis agitans is observed. In a general way, the signs in these cases suggest that associated movements are abolished. In other cases violent irrelevant movements as in chorea or slower writhing movements of the type known as athetosis occur. In any case, the execution of voluntary planned movement can be hampered by disturbances of muscle tone or by chaotic or perverted associated movements. Speech is frequently delayed and when acquired may be hard to understand, drooling is frequent, swallowing is frequently difficult and the expression of the face may be peculiar. All of these disturbances which may be the result of either abolition or chaos of associated movement suggest to the untrained observer that mental defect may exist. As evidence of mental defect, however, these symptoms have no validity whatever. In fact they ought to suggest that the stress of the injury is subcortical rather than cortical and that intelligence is presumably unimpaired.

3. *Cortex of Cerebral Hemispheres.* Going up now to the cortex, the voluntary planned movement is initiated on the surface of the brain. These impulses are propagated along the pyramidal tracts and eventually reach the anterior horn cells. Disturbance of this type of control is accompanied, as a rule, by a peculiar stiffness and hyperactivity known as spasticity. The responses to various types of stimuli are exaggerated giving rise to clonus and various other phenomena.

4. *Defects of Intelligence.* If one looks at Figure I it will be seen that only a small proportion is shaded. The unshaded residue has relatively little to do with direct control of motor phenomena but has all sorts of functions. On the whole there is a good deal of evidence that certain activities are centered in various places. For example, in front of the motor area extensive lesions are frequently associated with defects of intelligence, behind it lies an area in which lesions produce curious changes in sensation. Obviously this is no place for detailed discussion of this matter. All that I wish to emphasize is the great volume and vast importance of the part of the nervous system which serves other functions than the direction of muscle contractions.

EVALUATE ALL THE ELEMENTS

The greatest pitfall in attempting to make a rational physiological diagnosis is that the observer may fail to keep in mind that motor efficiency and mental integrity, though thoroughly related to each other are neither identical, mutually exclusive or any other comfortably definite thing. Only by trying to find and evaluate the various elements involved in producing a given disability will it be possible to reach a satisfactory conclusion.

With this amount of information, it is possible to proceed to the formulation of a definite plan for the management of the great group of children included under the general term of "cerebral palsy." If the observer tackles the problem as one of estimating a physiological situation and planning an educational routine which will utilize the intact residue certain obvious conclusions will be possible.

OBSTINATE OPTIMISM AND UNUSUAL PATIENCE

Naturally the supervisor is helpless if the intact residue is less than a definite minimum. It is evident that the first asset of the effective worker is optimism of a very obstinate sort, and patience of unusual degree. Anyone who takes a so-called "biological"

attitude of ruthlessness towards the relatively incompetent is no person to supervise handicapped children. Fortunately such unpleasant people have already been eliminated from this audience.

As a natural corollary of the necessary optimism, workers with this group will distrust diagnoses of mental defect until forced to accept them. In my opinion few doctors and fewer psychologists recognize fully the influence of motor defects upon most of the established mental tests.

Since the causes of cerebral palsy are largely operative in early life, the educational and nursing problems should be attacked in infancy and continuous supervision should be continued indefinitely. Contractures can be almost totally prevented in this way. In addition disastrous attitudes of pity or contempt on the part of associates can be avoided in large measure.

The principles of education are relatively simple but the details are endless. If we start off with the idea that one voluntary action is worth indefinitely more than one imposed upon the patient, it is obvious that planned, cheerful play is available at a time when stereotyped exercise is impossible. Then, it is clear that the level of expected performance should be set at a level challenging the ability of the child but not so high that failure is likely. Since a child may suffer from any combination of physiological disabilities it is necessary to adapt and readapt methods.

This paper is obviously an attempt to do many things. I have tried to expound technical neurological ideas and to advance more or less heretical opinions. But the point that I hope will be regarded with sympathy is this. Nurses, as long as they are optimists, may easily succeed where more technically erudite people, who are pessimists, may fail. I have no possible illusions about writing a definite paper on cerebral palsy, but I hope I have given you an idea of "cerebral palsy" as a group of interesting, soluble problems in education rather than a dull pitiful group of dependent cripples.

ADELAIDE NUTTING–LAVINIA DOCK PRIZE

For an Historical Essay Dealing with a Nursing Subject

In honor of these two pioneer writers of Nursing History a prize of one hundred dollars has been offered for the best historical essay submitted by a student or graduate nurse, before January 1, 1931. The conditions are as follows:

The subject must be one which is directly concerned with some important phase of nursing history.
The essay must show original research by the writer.
The essay should cover from 8,000 to 10,000 words and should be type-written.
There should be a cover page with full title, a table of contents, and a brief outline of the subject matter of the essay.
The essay should be fully documented with footnotes and should include a detailed bibliography.
The language used should be English, French or German.

Anyone wishing to enter the contest should write to the chairman of the History of Nursing Committee, Miss Nina Gage, 370 Seventh Avenue, New York City, giving her name, address, professional training, and experience, and two references. Each registered contestant will then receive instructions.

The judges will make their decision on the basis of:

The worth of the material—The sources consulted—The form of the paper—The clarity and originality of the presentation.

Prenatal Work in a Township

By Beatrice Heaton

Public Health Nurse, Millbrook, N. Y.

IN the township of Washington, N. Y., I am carrying on a generalized public health nursing program. We have a population of 3000 with an annual average of 36 births. We have 3 local doctors. Only one of these does any obstetrics. The nursing service is very fortunate in having him—a young man, health officer of the town and very coöperative in every way. The other two doctors are older and are not in active practice. I am the only public health nurse.

When I arrived here in January, 1929, my predecessor had just resigned. She had been in the township for years, was very much liked and had been educating the community in prenatal care. She had established a prenatal clinic at the suggestion of the Dutchess County Health Association which had been functioning 3 months. The clinics are now held monthly with the local physician in charge. A nurse from the Dutchess County Health Association helps me on clinic days. Transportation is a great problem. If patients are coming from the direction of Poughkeepsie the nurse from there picks them up on her way here. Otherwise, I have to depend on women of the village, many of whom drive. They and the members of my committee have been very helpful indeed in driving mothers to the clinic.

MEDICAL PERMISSION FOR A FULL PRENATAL VISIT

One of the first steps on arriving here was to obtain permission to make a full prenatal visit, including urinalysis and blood pressure. I secured my committee's consent to purchase necessary equipment, and asked the physician for his approval. He refers his patients to me and I see them between their office visits to him. I report back to him after each visit, either personally, by telephone, or in writing. This report back I feel is very important. It shows the doctor whether or not the nurse knows what to advise and is a way of securing his approval on the advice given.

ASSISTANCE AT DELIVERY

The nursing service here offers delivery assistance. We have sterile obstetrical packages to sell, or to give in case of emergencies. These are a great help to the patients who stay at home. The cost of the service is $5.00, the obstetrical packages $3.50, and patients seldom fail to pay. Although we urge hospital service as much as possible, we have a fair average of home cases and I attend practically all of these.

PATIENTS OF CITY PHYSICIANS

The patients who have registered with physicians in Poughkeepsie for delivery are difficult to find as these doctors do not report them to me as yet. When I find such patients I telephone the physician or go to see him. I explain the service and so far have been able to obtain consent to a full prenatal visit on every case as well as to have patients come to the clinic. I always follow a visit by a report and if abnormal symptoms are found, call the doctor up for orders. The fact that the Dutchess County Health Association has been very active facilitates my work in the city.

Another attraction to patients to have prenatal care is an arrangement made by Vassar Brothers Hospital in Poughkeepsie. It offers a reduced flat rate of $35.00 for ward and $60.00 for semi-private room to patients who have had prenatal care.

CASE FINDING

Besides the doctors reporting cases, my committee members sometimes give me names, I ask patients who might

know of others, and in generalized work, when school, preschool and infant visits are made, one knows many families and meets expectant mothers while making home visits. I always ask the school teachers, and one or two mothers in the Italian Settlement of the village are very coöperative and friendly and keep me posted.

The generalized program also helps in the entree to the homes. The weighing of preschool children, or of the mother herself is very attractive and, carrying scales as I do, I can manage this very easily. There is always some child or neighbor's child to refer to; but I find that the nurse preceding me was so well known and well liked by the entire community, that uncoöperative cases are relatively few. I follow the routines and advice of the New York Maternity Center Association and never drop a case, but keep calling occasionally, to say "hello" and gradually win confidence.

OFFICE VISITS

I urge the patients to come to me during my office hours if they do not live too far away. I have just been able to arrange to stay in the office one entire afternoon a week to try and get better coöperation in this matter. I make a point of telling the mothers about office hours and invite them to come in. Several have come from outside the township.

EQUIPMENT

There was no equipment when I came, but I am gradually getting it together. Trays and a baby layette are complete. I have a small baby exhibit.* I take this along in the car to show mothers in the country, which often breaks the ice with a reticent or uncoöperative patient. I am getting a little delivery bed now. The bed is loaned to me by a friend for use in the office. I have several abdominal binders for loan, and I have patterns of baby clothes made for me by my committee members to give or loan to the mothers. These are very much appreciated and do not scare a mother as a "store pattern" sometimes does if she is unaccustomed to them. I have no mothers' classes as yet, but I am suggesting them, hoping to create a demand. Of course I never have a great many patients at once and they are very scattered, so it is difficult to say whether classes could be managed.

I feel that unless a nurse loves prenatal work and feels it so essential that it will come first, excepting sick care, she will not draw the patients to her. This love of the work I am afraid, she may not have unless she has had training in prenatal work which will give her the practical pointers she needs to put the program across.

* See THE PUBLIC HEALTH NURSE, December, 1927, p. 599.

The Children's Fund of Michigan, established in May, 1929, through the gift of $10,000,000 from Senator James Couzens of Detroit, recently made the first public announcement of its program. The fund has arranged to assist counties that are endeavoring to establish public health units by setting up child-health demonstrations, with the hope that the counties will later be able to assume the financial responsibility for the work begun. In other counties the fund is lending aid to promote certain health provisions of benefit to children. The fund also intends to formulate a program for the establishment of mental-hygiene work in Michigan, and a survey has been undertaken to determine what may be the best method of instituting child-guidance clinics.

Relation of Psychiatric Social Work to Public Health Nursing*

By Lois Blakey
Mental Health Supervisor, Visiting Nurse Association, Minneapolis, Minn.

SINCE 1923 there has been a gradual filtering of people trained as psychiatric social workers into the public health nursing groups. What is the type and the significance of this relationship? What are its future possibilities in the minds of the leaders of both professions? The relation of the psychiatric social worker to professional groups in public health nursing agencies is that of a newly formed step-sister alliance, an alliance of individuals divergent in make-up, which is rich in potentialities for the happy development of each, but which is dependent for its permanency on each of the members making advances to the other. It is this step-sister relationship between the psychiatric social worker and the public health nursing groups which I would like to consider.

A WELCOME RELATIONSHIP

That the nursing group would welcome the relationship which is developing seems a very natural thing to one who considers the growth of nursing, for there has always been a keen interest in psychiatric problems. The acceptance of the psychiatric social worker is only a change of method rather than the acquisition of an entirely new interest. To the first desire to alleviate suffering, has been added the desire to understand its nature, and how to prevent it, but this is also the history of psychiatric social work. In fact, social workers, tracing the development of their own work, refer to the reforms in the care given mentally ill patients resulting from the vigorous work of Dorothea Lynde Dix. It is the nursing profession which claims her.

Not only have the nurses shown an interest in psychiatric problems, but they have reached out for better understanding of their origin. As a result, from the nursing profession has come literature to better acquaint its members with the new field of service. In 1913, before there was such a person as a psychiatric social worker, a nurse, Miss V. M. MacDonald, was chosen as executive secretary of the first society for Mental Hygiene, and from her interest in the work grew the book *Mental Hygiene and the Public Health Nurse,* which has become a primer for the nurse. Miss Maude Muse, recognizing the nurse's need for better training, prepared her book on *Psychology for Nurses* and the demand for the third edition within the first year of its publication attested to the interest which nurses throughout the country were showing in the problems of personality.

APPEAL TO THE SPECIALIZED GROUP

In these developments can be seen the efforts which the nurses themselves have put forward to advance the mental health aspect of the work. If there has always been this interest in the problem, why did the nurses turn to an outside group for the next stage of development? I think it was that the training in psychiatry which the nurses received was not equal to the training in psychiatry which the social workers received in the schools of psychiatric social work. It was the knowledge of psychiatry rather than the knowledge of social work for which the nurses felt the need. I believe this because most of the organizations which have psychiatric social workers first sought a nurse with psychiatric training, rather than a psychiatric social worker,

* Paper read at the General Session of the American Association of Psychiatric Social Workers, National Social Work Conference, June, 1929, San Francisco, Calif.

but were unable to find the person with the training they desired. The reasons for the lack of proper training for the nurses are many—the outstanding one probably is the fact that mental hospitals do not have the facilities for training general nurses, and general hospitals which have schools for nurses seldom have the opportunity to arrange the proper affiliation with psychiatric institutions.

CONTRIBUTION OF THE PSYCHIATRIC SOCIAL WORKER

Although it was the psychiatric training which the nurses sought in securing a psychiatric social worker as a member of the staff, I believe it has been found that public health nursing has more to gain from psychiatric social work than from merely additional courses in psychiatry. The social work aspect has meant that the nurse's interest has shifted from mental disorders to mental hygiene. For this reason the psychiatric social worker will continue in public health nursing agencies until a new type of training is developed which will be a modification of psychiatric social work, to fit the specific needs of a public health nurse.

The psychiatric social worker contributes not only knowledge of the psychiatric principles, but also a knowledge of the scope of the work of other agencies, and methods of their work. She is a factor in the harmonious relations between the public health nursing agencies and social service agencies because she can interpret each to the other, correct and prevent misunderstandings, and enlarge the general usefulness of both types of agencies. A knowledge of the principles of psychiatry is helpful to the nurse but even more valuable is a knowledge of the resources which will be available in correcting the problems belonging to the special field of the psychiatric social worker.

Why does the nurse need the special help which a psychiatric social worker brings to an organization? The usual comment is something like this—surely the nurse has enough to do to handle the problems for which she has had adequate training without branching into a line for which she has had little or no training and one in which there is no certainty of giving adequate aid. The answer to this comment is that the physical and mental cannot be separated. If the nurse's goal is health, good all around health, she will not be content to do only a mechanical job which will not lead the person to health. The first case which came to my attention after I joined the nursing staff showed this tendency:

> A young man had been brought into an emergency ward with a crushed leg and an amputation had been performed at once. He gave no history, talked to no one, refused to allow his wound to be dressed and as soon as possible left the hospital ignoring the instructions to return to out-patient clinic. The visiting nurse who was called in at this stage had no difficulty in dressing the wound but could not persuade the man to return to the hospital. Gradually the nurse drew out the story of the man's belief that the pain in his leg was caused by a nurse who had deliberately burned him. Still later in the acquaintance the nurse discovered that the reason for his refusal to return to the clinic was his delusion that the motorman of the street-car would burn him with the electricity.

Knowledge of the reasons for the man's non-coöperative attitude made it easier to adjust the treatment to his needs and with the healing of the wound, went also improvement in mental condition. Nurses want to understand the effect of physical illness upon personalities, creating invalidism, developing unwholesome attitudes of compensation or seclusiveness.

THE NURSE INNOCENTLY HARMFUL

Without a knowledge of some of the psychiatric factors in the case the nurse may be one important element in the continuation of a problem. This was the situation which was recently recognized by one of our nurses who had been going into a home of three children for many months, seeing that the doctor's orders on diet and general care were followed out. Each visit left her with a greater sense of the extreme devotion and attention given the children by the paternal grandmother in whose

home the children were staying. The grandmother's apparent desire for commendation for her self-sacrificing care was amply met by the nurse who praised her on every visit and commented on the mother's apparent lack of affection. The nurse, too, praised the thoughtfulness of the father who daily came to his mother's home to help her with her work. The little girl's temper tantrums which were "just like the mother's," the little boy's loud avowal before the grandmother that he would rather die than return to his mother, first made the nurse look upon the problem as a possible behavior clinic case. When some help was given in studying the situation, the nurse's sense of values in the case shifted astonishingly.

The paternal grandfather told the story of how "something seemed to be wrong" when he and the grandmother first started out to make a home together. He had quarreled with her first, but had grown tired, and for twenty years he had drifted into a boarder-lodger relationship which did not permit much dipping into family discussions. His youngest child, the children's father, became very much the grandmother's favorite: because of heart trouble from which he suffered, he was given many privileges, such as staying home from school, spending extra money for amusements to make up to him for his inability to enter athletics, and freedom from punishment for misdemeanors to prevent over-taxing him. When this son reached maturity, he had married the adopted daughter of a woman of means, six years older than himself. She had never learned to live on the small salary to which he was limited because of his heart trouble. In the problems which followed, the father turned again to his mother who suggested that she help by taking the children into her home, and openly criticized the mother.

In the recital of these few facts from the many in the case, the nurse quickly realized that what at first seemed well merited praise might possibly be harmful as it would only strengthen the grandmother's dominance over the new family, caused by her own need rather than by that of the family.

THE NURSE'S OWN ATTITUDE

The nurse's own attitude toward the patient is determined by her understanding of the mental condition of her patients. About a year ago, a nurse reported: "It just burns me up to see how Mrs. Smith sits there by the stove doing nothing, every single time John gets sick. I told her in a polite way that she was just lazy." When the mental health supervisor made a call she found Mrs. Smith in such a marked stage of depression that hospital care was at once resorted to.

I have tried to point out why public health nurses need the help of a psychiatric social worker. I also want to say that public health nurses can make a contribution to psychiatric work which cannot be made by any other group. This contribution lies in the relationship between nurse and patient.

THE NURSE'S CONTRIBUTION

The nurse's administrations to the physical body creates an intimate relationship resulting frequently in an outpouring of confidences, happy or tragic, annoying or amusing, which reveal many of the emotional problems of the human being. The nurse going about her task listening to the tale as it is poured out, changing not one whit the quality of her work, because of the nature of the confidences given, stands in a position to sense the conflicts in their unadulterated state, which the social worker calling in the home can never expect to gain.

The nurse is the passive listener, busy in her duties which aid in the impression of "no censure given" which the attentiveness of a social worker sitting with idle hands can not give. Freedom to talk, freedom to stop talking, without a silence which may become embarrassing because too long prolonged, or the danger of meeting the eyes of the social worker sitting in front or nearby, is the reason for the confidential attitude.

Occasionally one hears the charge of social workers against nurses that they are sentimental, ruled by emotion, quick to act without knowing the entire situation. There is the possibility that what there is of truth in this statement may be due to the nurse's lack of

knowledge of how she handles the confidences that come to her. She does not know the significance of the information revealed to her and therefore needs more training in interpreting mental processes.

There is another contribution which the nurse can make and that is in the early recognition of problems. The psychiatric clinics, the children's courts, the schools, and to a certain extent the social workers see the problems after they are sufficiently evident to be labeled behavior problems. The nurse has the opportunity of observing in the home from the prenatal period up to old age. The privilege of giving the young mother some conception of the principles of good health is a part of the prenatal instruction.

MENTAL HYGIENE OF PREGNANCY

The mental hygiene problem which pregnancy presents has been brought to the attention of all the mental hygiene supervisors because of its frequency or its reaction on the nurse. The depression which many of the patients receiving free service feel in the prospect of having one more person share the inadequate income is a real thing in addition to the many more subtle causes, and demands of the nurse a recognition of the psychiatric factors, a knowledge of social conditions in the community and an ability to teach the family how to handle more wisely the limited income that is theirs. The nurse has the opportunity of securing help at any early stage, and she must know whether to call in a psychiatrist or a social worker. Pregnancy is only one critical period at which the nurse is called into the home. At birth, death, adolescence, or the menopause psychiatric problems are revealed to her.

HOW IT WORKS IN MINNEAPOLIS

The chief function of the psychiatric social worker in the Minneapolis Visiting Nurse Association has been educational. About 16 per cent of the supervisor's time has been spent in actual class work with the nurses and 21 per cent in conferences with individual nurses on special cases. The remaining time has been spent on preparation for the educational work and on direct work with cases that were too difficult for the nurses to handle or required too much time. The choice of material for the group discussions has been made by the supervisor with the aid of her medical advisors. The actual cases of the nurses have been used whenever possible to illustrate the principles under discussion. This is an advisable method in most groups but particularly useful with groups whose entire training has centered about concrete things.

Once a year the new nurses on the staff are given a series of class discussions one hour a week. When these are complete the nurses are admitted to the regular weekly group discussions at the substations. The supervisor discusses with the nurse the individual cases which seem to present problems to the nurse. One of the greatest obstacles to the success of the cases has been the lack of time which the nurses have to devote to the problem. The change in the type of cases which the nurse refers to the psychiatric social worker is an indication of the extent to which they have grasped the teaching. The first type of case referred was always the feeble-minded, not always recognized as such by the nurses. As the nurse grasps more of the mental hygiene aspect of the class work, cases are referred on which more constructive work is possible.

RELATION TO THE PHYSICIAN

The relation of the psychiatric social worker to the practicing physician is one of the most delicate and important aspects of the work. Since it is a policy of the organization to carry beyond the second visit no case which does not have a physician in attendance, the mental hygiene supervisor has the opportunity of correlating her work with that of the physical phase. She has the obligation of following the doctor's lead, and of making clear to him the mental hygiene problem as she sees it. Frequently, the general medical man has little conception of the aims of the worker, but is willing

to work with her. The success of her work with the doctor generally depends upon the mental hygiene supervisor's ability to explain what type of help she needs on each case rather than the doctor's general knowledge of what the nurse and psychiatric social worker can and can not do.

THE GROUP RELATIONSHIP

What special problems does a worker from one field meet when she enters a group with different training?

There are certain handicaps and certain stimulating challenges. There is a general feeling among the nurses that a social worker cannot be effective unless she has had the training of a nurse. This can be satisfactorily answered in that the cases are carried only in coöperation with the nurses and therefore the patients do not lack for nursing attention. The fact that the psychiatric social worker is not a nurse assures the continued emphasis on mental hygiene without danger of the pressure of work among the physical by crowding out the equally important mental health aspect.

Another handicap the social worker must overcome is the feeling that the social worker will remain reserved and hold herself aloof from the group. This I believe is wholly a matter of individual personalities and is not a matter of professional attitudes. Along with this last handicap goes another one which I fear consists of an attitude held by a majority of the nurses; that the psychiatric social worker believes she is more capable of meeting the problems than are the nurses.

The challenges to the psychiatric social worker are many and real. There is the responsibility of formulating and assembling her own knowledge so that she can give it to others. There is the opportunity of determining what knowledge is needed for the best development of the public health nursing work. There is the chance of working with many doctors thereby obtaining many points of view, and there is the privilege of helping to correlate the various phases of public health and social work for the betterment of the community as a whole.

COUNSEL OF PERFECTION—TO A SCHOOL NURSE

Being physically fit. (Looking the part.)
Believing in and having a yearly health examination.
Carrying out promptly the health advice given at the time of examination.
Having a personal health program. (As to personal hygiene, health habits, etc.)
Practising it daily.
Being enthusiastic about health.
Stressing positive health.
Stressing prevention above correction.
Having and endeavoring to give to others the health viewpoint.
Being tactful and gracious in all school and home contacts.
Working in close coöperation with the school doctor, teacher, school authorities and parents.
Being courteous, patient, and a good listener, always.
Cultivating a pleasant voice and manner of speaking.
Working in close coöperation with community health officials and community health activities.
Taking a personal interest in every individual child.
Giving special attention to special class, handicapped children.
Endeavoring to secure 100 per cent health, in her assigned schools.
Being strictly ethical in relation to the family physicians, the health official and school authorities.

—Florence A. Sherman, M.D., Assistant Medical Inspector of Schools, New York State Department of Health.

In the Houseboat "Queen"

By Mabel Rainbow, R.N.
Visiting Nurse Association, Oakland, Calif.

IT had been a hard place for the visiting nurse to find. Twice she had turned back, but at last, pursuing ing a narrow dirt road strewn with broken bricks, she had come to the houseboat "Queen," lying in the estuary surrounded by piles of driftwood almost as high as the houseboat itself. Gas tanks across the street, vacant lots heaped with old bricks carried there from wrecked buildings, old wood everywhere, but in front of the "Queen" there was a little garden with cabbages, onions, sweet peas, and bright red geraniums all growing together. Inside the houseboat an old man was lying in a bunk with his bandaged foot elevated on a roll of bedding. This was Alex, this the environment in which he lived, and the place he loved.

Six weeks ago Alex met with an accident, a redwood block fell on his foot. A few days of neglect and trouble set in. "Gangrene" the doctor at the hospital said after the ambulance had taken him there. The foot was saved, however, and Alex's joy was great when he was allowed to return to the "Queen." Meanwhile the doctor telephoned the Visiting Nurse Association and gave instructions for daily dressings.

The inside of the "Queen" presents a quaint picture. A double bunk is in one corner, an oil cloth covers the floor, and old lace curtains cover the windows. Everything is neat and tidy.

An aged and devoted brother has been with Alex since the accident. The fondness they display for each other is quite unusual, but Alex says "Brother just can't cook." He forgets "Brother" is seventy-five!

Alex plays the violin, his violin is his companion. While the nurse dresses the wound he sometimes plays, and the pain is eased, he says. Some days a bouquet of sweet peas is picked, ready for her. One day she was invited to "get some onions out of the yard."

Alex is able to hobble around now on crutches. A bath robe and an army shirt were offered. Tears filled his eyes when these were taken to him. Alex has said feelingly, "I shall miss my nurse when she stops coming," and he means it.

The Place of the Public Health Nurse in Social Hygiene

By Edna L. Moore
Assistant Director, National Organization for Public Health Nursing

THE briefest, most comprehensive definition we have of Social Hygiene is by Professor M. A. Bigelow:

"Social Hygiene in America, includes those social health problems which, directly or indirectly, have grown out of the sex instinct."

Problems! Nurses! Why, of course, they belong together! What are these special problems and how do we meet them?

Social and health are restricting words used not without significance. They lead us to consider the basic unit of society, the oldest institution—the family. The health of the family is the sum of the health of its members, as the health of the community is the sum of the health of its families.

Ignorance, misunderstanding, superstition, misconduct and disease are the enemies of health and the targets for the social hygiene worker. They are open to attack on four main fronts: educational, recreational, legal (including protective) and medical. Educational and medical measures fall within the accepted program of public health nursing; while to provide for recreation and to secure adequate legal and protective machinery are the concern of good citizens everywhere. Consequently, they should receive the attention of nurses quite apart from their professional interest in the other phases. Also, there should be open lines of communication between the workers in the different fields.

Education to combat ignorance and misunderstanding of the sex instinct, which result, so often, in unhappiness, misconduct and disease, is education for right living based upon knowledge of the forces that govern human life and its perpetuation. The public health nurse, because of her established position in the community and her intimate contact with the home, has many opportunities to reach out into this field where educators are giving such splendid leadership. To grasp these opportunities and to accept the responsibilities they carry, demands, primarily on the part of nurses, an attitude of understanding and acceptance toward sex problems.

Similar problems present themselves in the medical field. Again our success depends upon our philosophy. Venereal disease clinics (so-called) are established, in the first place, for the protection of the community and, in the second place, to provide adequate treatment for those who cannot secure it for themselves. When men and women come to these centers and sense the feeling that their condition implies an act utterly reprehensible to us, how can we gain their confidence or help them to help themselves?

VENEREAL DISEASE A HEALTH QUESTION

We must be clear in our thinking. The venereal disease question is a health question from our point of view, and we should treat it as such to the exclusion of anything that might be confused with reform. Moreover, agencies exist whose main function is to deal with this aspect of the problem. We should be familiar with their policies and they should understand ours.

Syphilis and gonorrhea are communicable diseases. Medical knowledge concerning them is steadily increasing through study and research. The general public is being informed constantly. Official health agencies are providing facilities for diagnosis and treatment. Clinics are increasing in number and efficiency. Up to the present nurses have played a rather small part in this development. The time has come when we can no longer hold back, if we are to keep our place in the vanguard of the public health movement. We are conscious of in-

adequate preparation, which, combined with a lack of leadership and a multiplicity of other duties has kept us in more familiar paths. These difficulties must be met. Hence our course of action is defined. We need specific answers to three questions: How is community health affected by syphilis and gonorrhea? What are the community resources to find and treat those who are infected? What, precisely, can we do about it? For there remains much to be done if the race is to be freed from an overwhelming load of needless suffering and unhappiness, and the public purse relieved of one of its heaviest burdens.

THE CHALLENGE OF THE PROBLEM

Public health nursing organizations can make an important contribution by studying the needs and facilities of their communities. Moreover, they may find an opportunity to coöperate with official agencies and assume leadership in instances where officials may be hampered for obvious reasons—or supply the pressure needed to carry recommendations into regulations.

Congenital syphilis offers a challenge that is felt keenly by public health nurses. Too many obstacles separate the expectant mother from diagnosis and the pregnant syphilitic woman from adequate treatment. Too often the happiness of families has been blighted through stillbirths. Too long the ranks of the blind, the deaf, the crippled, the mentally incompetent, have been swelled through this channel. Surely we have reached the peak.

Already public health nurses are pioneering in prenatal work. Is it not logical procedure to strengthen and extend this service, working out standards as information is made available? Then, too, in preschool, school, and industrial nursing there are pregnant possibilities for helping in the discovery of congenital syphilis in time to avert some of the tragedies that stalk by its side.

Health and social organizations are studying the situation intensively, and are beginning to take measures to cope with it. The American Social Hygiene Association in annual meeting January, 1929, unanimously adopted the following resolution:

> WHEREAS, congenital syphilis is one of the most frequent causes of foetal and neonatal death, and of the greatest mental and physical disasters among those who survive, and
>
> WHEREAS, there are medical procedures which, when properly applied to the pregnant syphilitic woman, will almost certainly prevent congenital syphilis in the child, be it therefore
>
> RESOLVED: That the American Social Hygiene Association advocates the adoption of vigorous measures for the prevention of congenital syphilis, and especially directs its officers to promote the spread of information to the public regarding the great advantages of medical supervision early in pregnancy; to secure the coöperation of nursing, public health, and social groups with the medical profession in insuring the adequate treatment of every pregnant woman, thereby preventing congenital syphilis; and, in particular, to encourage those in charge of prenatal clinics to devote attention to the discovery and treatment of syphilis among all women who are in attendance.

Ultimate success in this will depend to a large extent upon the particular contribution that only public health nurses can give.

These words of Bliss Carman point to steps that we must follow: "We must care before we know, we must know before we do; nor yet, may we even be content with caring and knowledge until we add to them well-skilled efforts toward the realization of our ideal."

A TALK ON VENEREAL DISEASES TO GRADUATE NURSES

Excerpts from a talk given at Teachers College, Columbia University, by Walter Clark, M.A., M.B., Ch.B.L.R.C.R. (Edinburgh), Director of Division of Medical Measures, The American Social Hygiene Association, New York, N. Y. Printed in *Hospital Social Service* for September, 1929.

BECAUSE the venereal diseases have a moral and a social side, since the contracting of syphilis, in a majority of cases, involves some act which society regards as immoral, we have to approach their control from a point of view of conduct, and consequently we have to consider the whole question of the teaching of effective ideals. . . .

EFFECTIVE IDEALS

We must try to influence ideals. We must so instruct people that their conduct will be such that they do not expose themselves to the venereal diseases. Let me place that in a very plain way. The thing which I would ask you to bear in mind is that all medical people, nurses and public health workers have a direct responsibility for making sure that no one whom we serve, contracts a venereal disease through ignorance of its seriousness or of the methods of preventing it. That represents the bare minimum of social and professional responsibility.

It is often an extraordinarily puzzling thing for the nurse, or the doctor, or the social workers of a clinic to decide what to do about the question of secrecy. A patient may be in the gravest danger of infecting his wife and his children, and yet it may be extremely difficult for the nurse or social worker to say, "I am going to inform your wife, so that she may be protected." These cases usually have to be decided upon by a consideration of all the circumstances and usually the solution lies in getting the man himself to give up his secret by appealing to him for fair play for those with whom he is associated. . . .

HOME INSTRUCTION

It is necessary for the nurse to consider the question of what kind of instruction she is going to give when she goes to visit the home of a venereal disease patient. She needs to know whether the patient is in an acute stage, and that is information which she gets from the medical attendant. She may need to consider what kind of instruction she is to give to the wife and the children. I remember a case which I saw in Edinburgh not long ago. A man, who was suffering from gonorrhea, came to the clinic. He said everyone at his home was well. It was suggested that he bring his wife and children to the clinic for examination. The wife and the children went to the women's clinic and a male friend who was living with the family came to the male clinic. They were all found to be suffering from gonorrhea. One little girl had a gonococcal vaginitis, which proved to be very stubborn. One of the other children had a gonococcal ophthalmia. The male friend was suffering from an acute urethritis.

This is the kind of experience which impresses the nurse with the necessity for instruction which may best be given by the nurse or social worker who visits the family. No doubt the details of advice in each given case will differ, but no one should forget that it is of the greatest importance in cases of gonorrhea and syphilis to instruct the patient and his or her family, and bring them to the doctor for examination.

CASE-HOLDING WORK

"Case-holding work" I wish also to discuss briefly. By "case-holding work" I mean everything that is done in the clinic, or in the doctor's office, or in the hospital, to keep the patient under treatment. Here another of the general principles is involved, namely, the fact that the treatment and care of syphilis and gonorrhea are slow and tedious tasks. They require a long time, and the patient too often becomes

tired or discouraged with the whole process, and when he begins to feel comfortable once more, he discontinues his treatment and does not return to his doctor or the clinic. Everything must be done by the nurse and the doctor to hold patients for a sufficient period. The healing of the initial lesion or lesions of which the patient complains is no indication of cure. Consequently, I would stress the fact that all phases of "case-holding work" should contribute to impress the patient with need for thorough treatment which should be as considerate and painless as our best efforts can make it. Such little things as the sharpness and size of a needle are important. Patients do not enjoy being "harpooned" as they sometimes call it. It is important to bear in mind that the patient is a sick person who requires sympathetic attention and as humane treatment as it is possible to give him.

The venereal diseases offer the nurse, like the doctor, a problem and a challenge large enough and difficult enough to require our best effort. It is the nurse who has to deal tactfully and yet helpfully with the family and the patient. I know of no work where a higher order of diplomacy, discretion and good judgment is required than in dealing with the public and private nursing aspects of gonorrhea and syphilis.

TWENTY YEARS OF MENTAL HYGIENE

The National Committee for Mental Hygiene celebrated the historic occasion of the 20th anniversary of the founding of the committee with a dinner at the Biltmore Hotel in New York. Besides psychiatrists and psychologists from many parts of the country, educators, social workers and laymen were present.

Dr. William H. Welch, Honorary President of the National Committee and Director of the Department of History of Medicine of the Johns Hopkins University, presided. In his opening speech, Dr. Welch went back over the history of the mental hygiene movement, so extraordinarily advanced in this short period of twenty years that in 1930 the first International Congress on Mental Hygiene will be held in Washington—out of which will grow an International Committee, or League, to coördinate and stimulate the work of the National Committees. Speaking of the history of the National Committee he called attention to the singular fact that its historical aspect is centered "in one man and in one book."

Dr. William A. White, speaking later, said:

> For a hundred years patients had been leaving our public institutions for mental disease with a sense that if they had gotten well they did not owe it to the way they had been treated. In numerous instances they must have felt outraged at the experiences they looked back upon, at the cruelty, the callousness, the lack of sympathy with which they had been confronted during their confinement. But it was given to only one man who had had similar experiences to have these memories of his treatment strike deep to the very core of his being—and there, instead of rankling they took root, grew and produced the fruit which is now the mental hygiene movement. He also had been outraged but by some strange alchemy these outrages stirred him to creative activity. The genius—and I use that word advisedly—whose mind among a million saw opportunity where no one else had seen it for a century—that genius is Mr. Clifford Beers.

Other addresses were given by President Angell of Yale University and Dr. Frankwood E. Williams. The guests at the dinner were presented with "Twenty Years of Mental Hygiene," a brochure prepared for the anniversary, containing in interesting form data and information on the origin and development of the mental hygiene movement, together with articles on special phases. Dr. Salmon's report, published originally in 1919, "The Insane in a County Poor Farm," one of the most searching and moving descriptions of conditions existing widely only ten years ago, is here reprinted. A limited number of copies of the brochure are available, and can be obtained from The American Foundation for Mental Hygiene, Inc., 370 Seventh Avenue, New York city, price 75 cents.

Can Maternal and Infant Mortality Be Reduced?

Public health nurses frequently wish for supporting evidence that low mortality rates result when preventive maternity and child welfare programs are organized.

Valuable indication that fewer mothers and infants die among those reached by public health medical and nursing services is contained in certain figures just compiled for the child health demonstrations of the Commonwealth Fund and released for our use through their courtesy.

During the four-year period covered by this special study there were 10,444 births in the four demonstration communities. In 2,518 cases, about one-fourth of the total, nurses of the health department gave prenatal instruction and supervision in coöperation with the family physician. In the group under such supervisory care there were only eight maternal deaths in comparison with 60 in the group not served, 65 stillbirths in comparison with 383 in the group not served, and 40 infant deaths under one month in comparison with 297 in the group not served. The comparative mortality and stillbirth rates are:

	Maternal Deaths per 1,000 Births		Stillbirths per per 1,000 Births		Infant Deaths Under One Month per 1,000 Live Births	
	Under care	Not under care	Under care	Not under care	Under care	Not under care
All Demonstrations	3.2	7.6	25.8	48.4	16.3	39.4
Fargo, N. D.	3.9	5.4	17.0	44.2	9.3	49.4
Marion County, Ore.	0.0	3.8	6.2	37.5	16.7	31.4
Clarke County, Ga., total	6.5	15.2	30.4	70.1	33.6	46.2
White	4.8	6.3	9.7	44.0	29.3	31.7
Colored	7.9	28.6	47.6	109.6	37.5	69.7
Rutherford County, Tenn., total	2.5	8.3	43.1	49.3	12.9	39.2
White	1.8	7.3	38.9	46.7	9.2	34.4
Colored	4.0	11.5	52.6	57.4	21.4	54.8

In these four communities 6,234 infants between one month and one year of age had either field nursing service or medical supervision in health centers, or both, while 3,425 infants did not have such care. There were 113 deaths in the group served and 163 in the group not served. The comparative mortality rates in this age-group (calculated in relation to the number of infants still alive at one month of age) were as follows:

	Under care	Not under care
All Demonstrations	18.1	47.6
Fargo, N. D.	16.5	80.7
Marion County, Ore.	4.3	25.9
Clarke County, Ga., total	19.5	71.8
White	7.6	49.1
Colored	34.4	114.5
Rutherford County, Tenn., total	31.5	57.8
White	28.9	48.6
Colored	39.4	83.7

Where care was given the infant mortality rates were especially low for congenital causes, respiratory diseases, and diarrhea and enteritis. Among infants under one month of age the mortality rate from congenital causes, was 11.5 for the group served and 31.0 for the group not served. Among the older infants the rates for the groups served were 5.0 for respiratory diseases and 3.8 for diarrhea and enteritis, as compared with 14.3 and 13.4, respectively, for the group not served.

The Harmon Plan for a Retirement Income

By James I. Coddington
Executive Secretary, Harmon Association for the Advancement of Nursing, New York City

NURSES, like others, grow old. In an earnest effort to anticipate the day when all professional work must cease, most people are saving and trying to accumulate an invested fund for use throughout their retirement and old age. For some, such a "retirement fund" may be the only means of future support, for others it represents a desire to have an income of their very own to supplement family resources, which may or may not exist when most needed. It is perhaps the most important of all funds for a man or woman engaged in a profession; for, if once lost or completely spent *after* retirement, it cannot be easily replaced, and, because of advancing age and failing strength, it is then usually too late to re-accumulate a fund.

CONSERVE WISELY

The building up of a retirement fund, regardless of the method and even if started early in life, is not always an easy undertaking. It requires a degree of will power and the ability to resist the temptation of spending all one's earnings. It is still harder to conserve and wisely invest what one saves. If one has avoided the pitfalls of speculation (which a surprisingly large number did not in the recent collapse of the stock market, when many lost their entire savings) like all people who have ready money in the bank, one is continually beset by "friends" seeking to "borrow," or by others whose investment counsel may not always be expert or of the best, even though well-intended.

And speaking of ready money in the bank—every professional man and woman should have a bank account, even if they cannot afford a very large one—but think of how many "retirement funds," that have existed as ready money in a bank, have been nibbled away and completely spent for a few days extra vacation, a new hat, and the like, *before* retirement! When money for spending *after* retirement is kept with the money one sets aside for current expenses, both funds get badly mixed and both are usually spent before retirement. Such funds should be kept separate. It is safer.

LENGTH OF LIFE UNCERTAIN

Let us look many years ahead and assume that one has been exceptionally fortunate each year in one's investments. Assume that none of them has gone down in value or been lost and that there has been accumulated a substantial sum, the spending of which one wishes to spread out over the remaining years of one's life, so that each month a definite guaranteed amount will be received, right up to the very last month of life. If one knew the length of one's life the sum accumulated could be divided into equal parts, so as to have each month the same amount of income right up to the last month of life. There would be no danger then of spending the entire sum too early and being left without funds for several years before death. But no individual knows how long she is going to live.

Obviously, if one started at retirement and spent only the interest and none of the principal, the principal amount of the fund, if absolutely safely invested, would still exist at death. But interest alone will not give as large a sum to spend each month as if one also spent each month some of the principal, which may be done safely if invested in an annuity.

It is here that the investment of the retirement fund in an annuity is very advantageous. The insurance company issuing the annuity does not know

how long any person will live, but based on longevity and mortality tables on millions of lives, the insurance company is able and empowered by law to guarantee to pay through an annuity a definite monthly income right up to the last month of the annuitant's life. It is only through an annuity issued by an insurance company that one can secure such a guaranteed life income, covering an *indefinite* span of years such as the lifetime of an individual.

ADVANTAGE OF SMALL MONTHLY DEPOSITS

Few nurses, however, have available at any one time the substantial lump sums required for a single investment in an annuity. Realizing this, in the formation of the nurses group annuity system—The Harmon Plan—arrangements were also made so that the nurse could build up an annuity through small monthly deposits made throughout her earning career, or up to the time she selected for her annuity to mature and the income payments to her to commence.

The Harmon Plan represents the careful adjustment of a group annuity system to the requirements and needs of nurses in all fields of the profession. The details of the Plan and how to join, are fully described in a recently issued pamphlet entitled "Annuities for Nurses," a copy of which may be secured by writing the Harmon Association for the Advancement of Nursing, 522 Fifth Avenue, New York City. This Plan was approved by the joint boards of directors of The American Nurses' Association, The National League of Nursing Education, and The National Organization for Public Health Nursing, at their meeting in New York City the week of January 14, 1929. It is now helping many registered nurses to build up, during their earning career, an annuity which will provide a guaranteed monthly income throughout those long years ahead after leaving the profession of nursing.

Every registered nurse should have a "retirement fund" for her own protection. There is no safer or more convenient way of building up and making certain of a retirement income than through an annuity, which guarantees the income payments from the maturity of the annuity right up to the last month of life.

LEADING ARTICLES FOR JANUARY IN THE AMERICAN JOURNAL OF NURSING

The Nurse and the Public. By Virginia McCormick, Publicity Secretary, American Nurses Association.

Scudder Memorial Hospital. By Wilhelmina Noordyk, R.N., Scudder Memorial Hospital, Ranipet, Madras Presidency, India.

How One Registry Handles Its Work. By Mary Margaret Muckley, R.N., Executive Secretary, Minnesota State Registered Nurses Association.

Who Makes the Best Hourly Nurse? By Augusta M. Condit, R.N., Associate Superintendent, Instructive District Nursing Association, Columbus, Ohio.

Opportunities in Private Duty Nursing as Seen by a Layman. By Mrs. Josephine U. McClellan.

A Discussion of Two Representative Cases from the Wards of a Neurological Hospital. By Lelin Townsend, R.N., Educational Director, School of Nursing, Neurological Institute, New York City.

The Epileptic Psychosis. By LeGrande A. Damon, M.D., Craig Colony, Sonyea, N. Y.

Michael Angelo. By Mrs. Brooke P. Church, Westport, Connecticut.

Nurses Home at Hillman Hospital. By Gladys Ratley, Student Nurse.

The Pride of the General, Its Babies. By Mary K. Herwick, R.N., Supervisor of Nursery, General Hospital, Kansas City, Missouri.

ACTIVITIES *of the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

CHANGE IN EDITORIAL STAFF

Miss Carr has been editor of THE PUBLIC HEALTH NURSE since 1923. During these years the organization has gone through periods of change and uncertainty and yet has continued to grow in strength, stability and service. Such progress in spite of fluctuations does not "just happen." Doubtless many trends of things and individuals have made such development possible. But no one has contributed more and to no one is more honor due than to Miss Carr. Her wisdom, sensitive judgment, delightful whimsicality, and ever-friendly response have been one of the constant factors in all these years and have brought life more abundant to the organization and public health nurses throughout this and other lands.

For several years Miss Carr has felt and said that soon she must withdraw from such active work. She now feels that the time has come when this is possible. Therefore Miss Deming will become editor January 1, 1930. However, Miss Carr will remain as associate editor on part-time until August, 1930.

What Miss Carr has given and meant to the organization is irreplaceable—but also it is everlasting!

Miss Deming is welcomed as editor because she has already made a very real place for herself with the magazine and as a member of the N.O.P.H.N. staff. Therefore, it is with a secure feeling that this change is announced.

EXTENSION SERVICE

These are being busy months for Miss Davis, who has been getting in touch with many groups and many board members. Already returns are coming in—and growing correspondence asking for advice and requests for field services by the board member group.

SOCIAL HYGIENE

Miss Moore has had time to get acquainted with the N.O.P.H.N. and the American Social Hygiene Association and now is prepared to be called upon for help in relation to social hygiene programs. She will be glad to consider requests to meet groups in staff conferences on institute programs and other group meetings;

To present Social Hygiene as an integral part of an aggressive health promotion program;
To trace the course of syphilis and gonorrhea stressing the importance of early diagnosis and treatment, with adequate casefinding to reduce sources of infection;
To emphasize the necessity for immediate action in the prevention of congenital syphilis;
To make practical suggestions, in keeping with state and local regulations;

and with local agencies to study and advise as to the development of the social hygiene program.

STATISTICAL DEPARTMENT

This department has gathered the latest figures on the registration of students in post graduate courses—published in this number—and is bringing the material in our loan folders on delivery and hourly appointment services up to date.

SERVICE EVALUATION COMMITTEE

At least 24 public health nursing organizations are busily at work gathering the material that is to serve as the basis for reconsideration of the method of evaluating services. The cities working on the study are Albany, Buffalo, Charlestown (W. Va.), Cleveland, Denver, Detroit, East Mauch Chunk, Galesburg, Holyoke, Louisville, Madison (Wis.), Middletown (Conn.), Minneapolis, Nashville, Newark, New Haven, Portland, Providence, Richmond, San Francisco, Terre Haute, Topeka, Washington (D. C.), York.

FIELD STUDIES AND TRIPS

Miss Tucker participated as special consultant in A.P.H.A. study in Nashville. This study revealed an exceptionally interesting and sound method of organization. Miss Tucker also spent a very satisfactory day in Dutchess County, meeting many board members and public health nurses carrying on programs in small communities.

STUDENTS REGISTERED IN ACCREDITED COURSES

Following the yearly practice of the N.O.P.H.N. to gather information about the number of students registered in the accredited courses of public health nursing, we are publishing the information received from 10 of the 11 institutions giving such courses. No information has been received from the Department of Hygiene, University of California.

NUMBER OF STUDENTS REGISTERED IN ACCREDITED COURSES OF PUBLIC HEALTH NURSING AND NUMBER OF CERTIFICATES AND DEGREES GIVEN ACADEMIC YEAR 1928-1929 AND SUMMER SESSION 1929

State	Institution	Year	Total registration	Graduate nurses registered	Undergraduate nurses registered	On full time schedule	On part time schedule	Cert. and Degrees given		
								Cert.	B.Sc.	M.S. or M.A.
		Aggregate registration	1455	1344	111	1106	349	138	46	4
Mass.	Simmons College School of P. H. Nursing Boston	Year 1928–1929	105	63	42	104	1	7	3	—
Mich.	Univ. of Michigan Dept. of P. H. Nursing Ann Arbor	Year 1928–1929 Summer Session	77 68	77 68	— —	11 68	66 —	5	4	—
Minn.	Univ. of Minnesota Dept. of P. H. Nursing Minneapolis	Year 1928–1929 Summer Session	38 87	37 85	1 2	31 78	7 9	22	7	—
N. Y.	Columbia University Teachers College Dept. of Nursing Education New York City	Year 1928–1929 Summer Session	372 156	372 156	— —	137 156	235 —	19*	16	3
Ohio	Western Reserve Univ. Sch. of Applied Social Sc. Cleveland	Year 1928–1929 Summer Session	38 35	33 35	5 —	38 22	— 13	16	5	1
Ore.	University of Oregon Sch. of Social Work Portland	Year 1928–1929	7	7	—	6	1	7	—	—
Penn.	School of Social and Health Work Dept. of P. H. Nursing Philadelphia	Year 1928–1929 Summer Session	21 20	21 20	— —	16 19	5 1	7	—	—
Tenn.	Vanderbilt University George Peabody College Dept. of Nursing Education Nashville	Year 1928–1929 Summer Session	214 75	214 75	— —	207 71	7 4	5	—	—
Va.	Richmond School of Social Work Richmond	Year 1928–1929	23	13	10	23	—	6	—	—
Wash.	Univ. of Washington Dept. of Nursing Seattle	Year 1928–1929 Summer Session	90 29	43 25	47 4	90 29	— —	44	11	—

* 19 diplomas in nursing given in connection with B.Sc. degree and M.A. degree.

This year, in addition, information was gathered as to whether there is an alumnae association of the public health nursing course, and, if so, what are the activities of the association. Five of the ten institutions replied that their public health nursing course has its own alumnae association. In the five other institutions there is no alumnae association for the public health nursing course separate from that of the institution as a whole.

Institution	*Activities of Alumnae Association*
Simmons College, School of Public Health Nursing	Loan fund
University of Michigan, Department of Public Health Nursing	Yearly social news letter Loan fund Scholarship fund
Columbia University, Teachers College, Department of Nursing Education	Special programs at alumnae meetings Loan fund Adelaide Nutting Historical Collection
Western Reserve University, School of Applied Social Science	Annual Bulletin Four meetings a year Entertain student group in October and June Loan fund
University of Washington	Loan scholarship fund

N.O.P.H.N. Statistical Service

STOP, LOOK, LISTEN!

Plans for the Biennial Program are developing apace. Bigger and better—which means smaller meetings, shorter speeches, and more time for discussion. Make your plans now because you cannot afford to miss this convention.

MIMEOGRAPHED BULLETIN

One of the minor decisions of the Convention Committee, but one calculated to bring considerable comfort to convention goers, is that concerning the daily bulletin. The old bulletin board method with its congestion is to be eliminated by this simple expedient. It will contain notices of changes of meeting times or place, of special sessions, social events, and those other items that usually find a place on the bulletin board.

TRANSPORTATION

Definite progress is reported in matters of transportation. Chairmen for the transportation districts have been appointed by Mrs. Alma H. Scott, R.N., Transportation Chairman, as follows:

North Atlantic States—Emily J. Hicks, R.N., New York State Nurses' Association, 370 Seventh Avenue, New York City.

New England States—Helene G. Lee, R.N., 420 Boylston Street, Boston, Mass.

West Coast States—Cora E. Gillespie, R.N., 327 Cobb Building, Seattle, Wash.

South Central States—Mrs. C. H. Ray, R.N., 2307 Fillmore Street, Amarilla, Texas.

North Central States—May Kennedy, R.N., 6400 Irving Park Boulevard, Chicago, Ill.

Gulf States—Mrs. B. S. Cawthorne, R.N., Bureau of Public Health, City Health Department, Memphis, Tenn.

Mountain States—Anna C. Jamme, R.N., 609 Sutter Street, San Francisco, Calif.

South Atlantic States—Jane Van de Vrede, R.N., 131 Forrest Avenue, Atlanta, Ga.

FOR THE EAST

Plans have been completed with the Baltimore and Ohio Railroad, and with the Chicago, Northwestern, and the Chicago, Milwaukee, St. Paul and Pacific railroads for the operation of special trains.

June 7, 1930, is the date for these trains which will leave New York via the B. & O. and will stop for convention goers to join those already aboard at Elizabeth, Philadelphia, Baltimore, Washington, Pittsburgh and intermediate points.

The itinerary of this special group of trains is as follows:

Saturday, June 7

Lv. New York, 42nd Street Station, B. & O. R. R.	10:35 A.M.
Lv. Philadelphia, 24th and Chestnut Streets, B. & O. R. R.	1:23 P.M.
Lv. Baltimore, B. & O. R. R.	3:25 P.M.
Lv. Washington, D. C., B. & O. R. R.	4:30 P.M.

Sunday, June 8

Ar. Chicago, B. & O. R. R.	1:30 P.M.
Lv. Chicago, C. & N. W. or C., M. & St. P.	3:00 P.M.
Ar. Milwaukee, C. & N. W. or C., M. & St. P.	4:45 P.M.

PROGRAM PLANS

The first announcement of the program plans will be made in the February issue of this magazine. The Convention Committee has made recommendations to the three program committees relative to speakers for joint sessions.

The National Organization for Public Health Nursing has appointed Sophie C. Nelson, R.N., of Boston, as Chairman of its program group. Serving with her are:

Winifred Fitzpatrick, R.N., Providence; Helen M. Erskine, Chambersburg; Mrs. Whitman Cross, Chevy Chase; Helen Hartley, Stockton; Mrs. Elizabeth Soule, R.N., Seattle; Mrs. Kathryn Schulken, R.N., Denver; Olivia Peterson, R.N., Minneapolis; Grace Ross, R.N., Detroit; Mary C. Chayer, New York; Pearl McIver, R.N., Jefferson City; Jessie Marriner, R.N., Montgomery; Juanita Woods, Richmond.

CHILDREN WITH DEFECTIVE VISION

Every nurse now and then comes in contact with children having such seriously defective vision that even after correction or treatment they cannot make use of the ordinary school equipment. They are not blind children, hence are even worse off in a school for the blind, where the avenue of educational approach is tactile, than in a regular grade.

Many cities have established sight saving classes for such children in their public school systems, and teachers and nurses are reporting them as candidates for this special education; there are, however, many communities, urban and rural, that have so far made no such provision. Perhaps by the time it is made it will be too late for the children who are now suffering from these difficulties.

Until such provisions are general, The National Society for the Prevention of Blindness, 370 Seventh Avenue, New York City, will be glad to assist any nurse or teacher having such children under her care by advising with her in regard to educational material, lighting conditions, physical exercises, and the adaptation of the regular school curriculum to the special needs of such children. To be able to give intelligent help, it is necessary to know something of the eye conditions from which such children are suffering.

BOARD AND COMMITTEE MEMBERS' FORUM

Edited by VIRGINIA BLAKE MILLER

Board Member, Instructive Visiting Nurse Society, Washington, D. C.

EXECUTIVE COMMITTEE OF THE BOARD AND COMMITTEE MEMBERS SECTION

The Executive Committee of the Board and Committee Members Section held an interesting and stimulating meeting in Washington, D. C., on November 22nd.

Miss Evelyn Davis, the Secretary of the Section, gave a report of her work to date. Out of her report grew an outline for a program for the section.

Some of the high points of interest were as follows:

To stimulate interest in state lay organizations. Where there is a State Organization for Public Health Nursing, to urge the lay people to become a section. Where there is no S.O.P.H.N., to have an organization similar to the Massachusetts Association, but plan to meet at the same time as the state nurses meeting.

To appoint an education committee to work with Miss Davis in planning Board Education and suggested programs for Board meetings. Mrs. Richard Noye of Buffalo was appointed chairman of this committee.

To encourage the reading of the Forum in THE PUBLIC HEALTH NURSE magazine, and to send in material for it.

To encourage institutes and to offer assistance in working out programs.

To stimulate interest in the Biennial program, and to urge Boards to send representatives to this meeting. (The program will be published soon so that all can see the interesting meetings planned for all, and especially for Board members.) A notice is to go out to presidents of Boards to read at their meetings asking for questions for discussion at the Biennial. Members are urged to send in suggestions.

MRS. WHITMAN CROSS, *President.*

The Fifteenth Annual Meeting of Directors of Visiting Nursing Associations of Massachusetts was held in Boston on November 13 and was attended by 225 persons, representing 73 nursing associations. After a short business meeting, Dr. George H. Bigelow, Massachusetts Public Health Commissioner, spoke on "Some Present Day Obligations for Visiting Nursing Associations." He emphasized two points—first, the relation of the public health nurse to the free clinic, and urged that the nurse consider the economic situation of the patient, and not send to the free clinic those who could pay a fee to the private physician; secondly, he suggested the formation of a public health advisory council, consisting of representatives of all agencies concerned with public health in a community—as the board of health, school committee, the tuberculosis and the visiting nursing associations—to work out a joint program.

Miss Florence Patterson, Director of the Boston Community Health Association, discussing Dr. Bigelow's points, called attention to the fact that the private physician is not able to offer the follow-up service of the public health nurse to the home, and suggested that the time might be near when public health nurses could offer to private physicians the same service they offer to clinics. In regard to a public health advisory council, Miss Patterson was in complete sympathy with the plan, but suggested, as a method of getting

coöperation among groups where it does not exist, that some new and obviously needed project be undertaken—some specific new united undertaking would be more likely to succeed than discussing a difficult situation already in existence. If a workable plan on a small scale is established, it may easily be extended to apply to the whole program.

Miss Evelyn Davis, the new secretary for the Board Members Section, was then introduced. Miss Davis spoke on the work of the National Organization for Public Health Nursing, especially as it concerns Board and Committee Members.

After luncheon, Mrs. Mary Swain Routzahn of the Russell Sage Foundation gave a stimulating address on Publicity, emphasizing various types of annual reports, their good and bad points, and pointing out their value as publicity. The meeting closed with Mrs. Billings, Board Member of the Hingham Visiting Nursing Association, showing a series of charts which had been used to explain the work at an annual meeting. The meeting adjourned with evident satisfaction on the part of those attending, and expressions that it had been worth coming from all parts of the state to attend.

The Public Health Nursing Association of Ann Arbor held its first Institute in the Michigan League Building on November 6th.

The object of the Institute was not only to introduce the new members to the old members, but to interest the general public and to give them the opportunity of becoming more familiar with the work of the Association and its plans for future development.

At the morning meeting reports of the Association Committee were presented. In the absence of Mrs. Barnes, Chairman of the Nursing Committee, Miss Edith Stoll, Supervising Nurse, gave an outline history of the development of the work in Ann Arbor from the days when the Hospital Circle of King's Daughters sponsored one visiting nurse who rode a bicycle or walked from one end of the town to another, to the present time when the Association employs the entire time of four nurses and keeps three automobiles in constant use. This was followed by an interesting account of the average day of a public health nurse and a demonstration of her technique upon entering the home of a patient.

Guests from Detroit and Toledo were present at the luncheon. At the afternoon session Miss Morehouse, Superintendent of the Public School Nursing Service of Detroit gave a comprehensive account of the work done in connection with the Detroit schools, stressing the many efforts made to safeguard the health of the growing child, while doing everything possible for the sick children.

The last and principal speaker of the day was Miss Winifred Rand of the Merrill-Palmer School of Motherhood of Detroit and a member of the Board of the National Organization of Public Health Nursing. Miss Rand traced the history of the science of nursing from its early unorganized days to its present-day highly organized and highly respected efficiency.

Although the attendance at this first Institute was relatively small, those present were most enthusiastic over the success of the venture and plans are already being formulated for making the Institute an annual occurrence.

The New York State Federation of Women's Clubs and the Congress of Parents and Teachers held recently an interesting two day Health Institute in New York City. The purpose of the Institute was to teach lay workers how to recognize the health needs of their community and to bring to the attention of the women of the state health problems and facilities for handling these problems in their local communities, in order that they may intelligently assist the state and local departments of health in their program of health promotion.

Board members will be especially interested in the announcement on page 39 in this number of Miss Moore's plan for helping local agencies in developing a social hygiene program. Also, in Miss Tucker's review of the important questions taken up at the meeting of the N.O.P.H.N. Executive Committee—page 645 in the December number.

POLICIES AND PROBLEMS OF PUBLIC HEALTH NURSING

The questions published here which concern industrial nursing were sent in to the National Organization for Public Health Nursing by various nurses active in the industrial nursing field. THE PUBLIC HEALTH NURSE, following its usual custom, has attempted to gather a few suggestive answers from experienced leaders in this same field. It is hoped that others will feel inclined to send in opinions based on their personal experience. There will be further questions and answers in a future number of this magazine.

What is the duty of the industrial nurse toward employees in whose homes there is a case of diphtheria? There is no plant doctor in the industry.

The nurse should consult the physician under whom she works in the plant if there is one. She should familiarize herself with the local and state regulations in regard to the control of communicable disease. If there is no plant physician as suggested by the question the nurse will have to be largely guided by the advice of the health officer. It may be that the plant employee is not living at home during the time a case of communicable disease exists at his home, or that arrangements are made so that there is no possible chance of the worker having contact with the case. The possible contact of the worker while in the plant would also have to be considered, whether he has any contact with other workmen and whether any of the other workers that he contacts have children, or whether he has any direct contact with children. Assuredly no health officer or family physician would authorize a worker to needlessly expose other families.—*James Wallace, M.D., Associate Field Director, The American Public Health Association.*

A culture should be required before such an employee is permitted to return to work and it should be stipulated that this employee does not come in contact with patient.—*James A. Bell, Health Commissioner, Columbus, Ohio.*

I should say that the question of release of cases or contacts in diphtheria is a problem for the health officer. However, an industrial plant may establish its own regulations with respect to its own employees, to be enforced through the medium of the public health nurse. If a condition arises whereby a health officer, because of either laxity in his administration or because of his unwillingness to follow accepted procedures, should release contacts for return to work without negative cultures, I believe that it would be quite within the right of the employer to have his own regulations, enforceable through the nurse, that such employee shall not return to work unless there be a negative culture report. The industrial plant management can, of course, add their own regulations to those which the health officer may have promulgated for the city as a whole.—*Henry F. Vaughan, Dr.P.H., Commissioner, City of Detroit, Mich.*

There is certainly in such a case a moral responsibility for the nurse to communicate with the local health officer and find out whether the individual in question is or is not a carrier.—*C.-E. A. Winslow, Dr.P.H., Yale University.*

If the man who runs a cafeteria in a plant is independently employed and not considered one of the employees of the said plant, is the medical department of the plant responsible for his semi-annual examination required by the city?

The responsibility for the examination would depend on what the city requirement set forth. If it stated "every person employed in a plant" must have the examination, the interpretation might differ from "every person employed by a plant." In a case where a man runs a cafeteria for a plant, no matter how employed, for the protection of those regularly employed, the cafeteria man should be examined by the medical department of the plant. The local sanitary rule or ordinance would have to be consulted and interpreted, but no matter how it read, the examination should be wholly satisfactory to the plant people and should therefore be done by the plant's medical representatives, unless the local health department arranges for such examinations.—*James Wallace, M.D., Associate Field Director, The American Public Health Association.*

It is my belief that the plant management would not be responsible for the physical examination required by the city. Such responsibility should, in my judgment, rest squarely

on the shoulders of the manager or owner of the cafeteria, which I understand is quite independent of the plant management.—*Henry F. Vaughan, Dr.P.H., Commissioner, City of Detroit, Mich.*

The case should be reported to the city department having control of the work.—*James A. Bell, Health Commissioner, Columbus, Ohio.*

Should a nurse or a clerk make the first follow-up visit on absentees?

Due to the fact that much of my time is given to safety organization and to the handling of all industrial claims, in addition to the general routine of health education and first aid as practiced in my department, my work is of necessity confined for the most part to the hospital and to the plant. I believe, of course, in the need for follow-up visits in many cases of illness, and have frequently found it wise to reassure myself that a sick employee was receiving the proper medical attention, but thus far home visiting has not been a recognized phase of my work. Our Mutual Aid Association has a rule to the effect that the hospital department must be notified at once and at stated intervals if the sick employee is to receive benefits while absent from work. This ruling keeps me fairly well in touch with sick employees, and a close contact is maintained with injured employees because our examining physician, a part time man, also attends the majority of our accident cases which involve loss of time.

If a definite follow-up program is to be carried on in a plant I should consider a nurse, rather than a clerk, the logical one to make home visits. A clerk would be regarded by many employees as a species of truant officer, whereas a nurse, with her ability to recognize sickness and give helpful advice, is as a rule a welcome visitor in the home of the average employee.—*Marion Page, R.N., Welfare Department, The Richardson Company, Cincinnati, O.*

If the factory employs only one nurse, her calls away from the factory should be reduced to a minimum. Occasionally it will be desirable to send her to the home of a sick employee. If a visiting nurse is employed by the factory, she should do all visiting. If she is unable to so conduct herself that her visits are welcome, she should be replaced. With the right type of nurse and the right attitude of management toward employees, I should never fear that a follow-up of all absentees by a nurse would hurt the prestige of the factory medical department. There is a great deal more to this, however, than *who* makes the follow-up call.—*Eleanor H. Little, Assistant Supervisor, Industrial Relations, U. S. Rubber Company.*

This depends—if someone knows the absentee is sick or there is sickness in the family the nurse should be the first to go. Otherwise, it seems to me the first follow-up visit should be made by someone outside the medical department. If the nurse is needed, she can make the next visit. Above all, we do not wish the employees to feel in any way that the medical department is acting as a truant officer. We wish to be welcomed in the homes and we will not if the management uses us as detectives.—*Evelyn L. Coolidge, R.N.*

I think, decidedly, that a nurse should make the first follow-up visit on an absentee.—*Anna L. Hawkins, R.N.*

In what way can an industrial nurse educate the employees in good health habits aside from her contact with them in the plant hospital or first aid room?

It is difficult for me to conceive of an industrial nurse's activities aside from this contact. One of my theories is that in the psychological approach to any problem there shall at least seem to be direct connection between cause and effect. In other words, what the industrial nurse does should be based upon the conditions which she finds in the first aid room: A man begins to report headaches. He has recently been transferred. Is there anything in his new working conditions which is responsible? This takes her out into the factory. It may be she has to teach the foremen health habits, or possibly she has to give the man a message for his wife's use in her culinary activities. I can see no end to the ramifications of such health education. But it seems to me the impetus should always have had its source in conditions brought to light in the first aid room. Otherwise the industrial nurse takes on the rôle of a reformer. As such, she may readily become a nuisance to both management and employees. The result is disastrous.

I can think of one exception. I hope the time will come when we shall see closer coöperation between the local community Health Department and the industrial medical departments. Under such a situation, it would seem very logical if the community Health Department were putting over a drive of Schick Tests in the schools that the industrial nurses should be asked to coöperate, even to the point of interviewing individual fathers or mothers. Care would have to be taken to make this a personal advisory contact only. It would be most undesirable for the employee to feel that his or her job was involved.

But to go back to the original question: With the right approach I can see no limit to

an industrial nurse's possibilities. They certainly can cover, in addition to personal hygiene, sanitation of toilets, ventilation of work rooms, shoes of women workers, malnutrition groups and personal advice regarding members of the family not employed. Education along any of these lines involves teaching of health habits. The place of contact is important only as it seems natural and not forced.—*Eleanor H. Little, Assistant Supervisor, Industrial Relations, U. S. Rubber Company.*

First of all setting them a good example by being herself in perfect health. Second, by distributing and explaining to them health pamphlets. Third, being one of them as far as possible in health activities outside the plant such as hiking, swimming, club activities, etc.—*Evelyn R. Coolidge, R.N.*

A good sympathetic nurse, by gaining the confidence of the employee, especially a visiting nurse, through her contact with the family, is extremely valuable in educating along the lines of good health habits.—*Josephine L. Billings, R.N., Medical Department, New York Stock Exchange.*

Should the industry pay for one or two professional magazines for the nurse's use?

It is my feeling that the Management should pay for such professional magazines and other publications as deal primarily with *nursing service in industry.* Such periodicals as are purely professional, I think should be a matter of personal expense. This also applies to membership in any organization dealing with matters pertinent to her work.—*Mary Elderkin, R.N., Medical Division, Industrial Relations Department, Union Carbide Co., and Affiliated Companies.*

The answer many industrial nurses of my acquaintance have given to this question has been: "Try and get it!" Fortunately the management of my company never makes it necessary for me to expend too much energy in arranging for the hospital department to be provided with the recognized nursing periodicals. The words, "Please order" or "Please renew" invariably bring to the hospital the *"American Journal of Nursing,"* "THE PUBLIC HEALTH NURSE," *"National Safety News"* and any other literature I think can be of assistance to me in my work. Just as our laboratory has need of certain chemical publications and the sales department its paper trade journals, so does the hospital need its professional magazines. These are regarded as an essential part of the working equipment needed to keep the department in touch with recognized nursing authorities and with modern methods and ideas.—*Marion Page, R.N., Welfare Department, The Richardson Company, Cincinnati, O.*

I pay for my own magazines.—*Laura J. Strum, R.N., Suncook Mills, Suncook, N. H.*

All industries subscribe to technical and scientific magazines of interest to various foremen and other executives which will keep them abreast with the times and aid them in their problems. I see no reason why those in charge of the medical department should be treated differently from the heads of other departments. We certainly are as keen as anyone to keep up to date in our work. There may be articles read in the different professional magazines which have no direct bearing on our individual problems in industry, but we need to know the progress being made in all types of nursing. I should say, yes the industry should pay for one or two professional magazines.—*Evelyn R. Coolidge, R.N.*

I do not see why the industry should furnish magazines for the nurse's use.—*Anna L. Hawkins, R.N.*

Yes. In my organization, the New York Stock Exchange, doctors and nurses are permitted to order any professional magazine they desire, as we feel this is one way the staff keeps informed of new methods, etc.—*Josephine L. Billings, R.N., Medical Department, New York Stock Exchange.*

NEWS NOTES

News has come of the organization of the American Mouth Health Association—the purpose of the Association is to diffuse among the lay public an understanding of healthful living and how it may be obtained, with particular reference to mouth health. The Association seeks to educate the laity in the fundamentals of mouth health and in the important principles disclosed by laboratory and clinic research.

The general nature of the activities of the Association shall be educational, scientific and benevolent, for public service and not for gain or profit.

The Association will establish a central bureau of mouth health education of national scope and purpose, guided by a large board of recognized authorities.

Columbia University Extension in coöperation with the De Lamar Institute of Public Health and the National Health Council, will offer in the spring of 1930 a course on Principles and Problems of the Public Health Movement. This course will be condensed into two weeks of special lectures and study. The dates of the course are March 3 to 15. The course will be given under the direction of Dr. Philip P. Jacobs, Director of Publications and Extension of the National Tuberculosis Association.

The fee for the course will be $10. The usual University fee will not be charged. Students may register either at the office of the Registrar at the University, Room 315, University Hall, 116th Street and Broadway, or by mailing their application to the Registrar of the University, together with check or money order for $10.

The course will be held in Room 200, East Hall, Russell Sage Foundation Building, at 130 East 22nd Street, New York City. The hours for the course are from ten to twelve and from two to four, daily, with the exception of Saturdays when the afternoon session will be omitted.

For further information write to Dr. Philip P. Jacobs, National Tuberculosis Association, 370 Seventh Avenue, New York City.

The fifty-seventh annual meeting of the National Conference of Social Work and Associate Groups will take place in Boston June 6 to 14. More than forty groups in various fields of social work will meet at that time.

Attendance at the Conference is open to any who wish to come. Headquarters will be at the Statler Hotel. Evening sessions will be at the Boston Gardens.

Hotel reservations should be made immediately with J. Paul Foster, 80 Federal Building, Boston.

Further information may be obtained from Howard R. Knight, General Secretary, National Conference of Social Work, 277 East Long Street, Columbus, Ohio.

The ninth annual convention of the International Society for Crippled Children, Inc., will be held at the Royal York Hotel, Toronto, Ontario, Canada, March 17–19, 1930. Programs may be obtained from the International Society for Crippled Children, Elyria, O.

The Annual Meeting of the American Heart Association will be held on Monday, February 3, 1930, at the New York Academy of Medicine, Fifth Avenue and 103rd Street, New York, N. Y.

The Brookline Health Center, which is the health unit of the Brookline Friendly Society of Brookline, Massachusetts, has added to its staff a mental hygiene worker. This department has been made possible by the Metropolitan Chapter of the American Red Cross which is helping to finance the

demonstration. The experiment is planned for two years and Mrs. Margaret Kent Osgood has been appointed to the position of Mental Hygienist of the Brookline Friendly Society. Her time will be divided between the Health Center and the Family Welfare Society.

Mrs. Osgood is a graduate of Radcliffe and received her Master's degree at Smith College in 1924. She has been associated with the Institute of Juvenile Research in Chicago. The Brookline Health Workers are looking forward to working out mental hygiene problems.

Plans have been announced for the association of three important Boston institutions—the Tufts College School of Medicine, the Boston Dispensary, and the Boston Floating Hospital—to form a New England Medical Center, to be erected in the heart of Boston. The purpose of the center will be to train family physicians for the smaller communities of New England and to provide more adequate relief for needy persons who require medical care. The three institutions will continue to maintain their separate identities but will operate under a joint administrative board.

On January 1, 1930, the Commonwealth Fund will inaugurate a new major program in the health field, and will establish, to administer it, a Division of Public Health. Dr. William J. French, who was the first director of the Fargo child health demonstration, and then took charge of the Austrian health program, will be director of the division. The assistant director will be Theresa Kraker, R.N., formerly associate director of the National Organization for Public Health Nursing, who has been associated with the Fund for the past three years.

The new program is a fresh attack on the problem of bettering rural health. It will be centered in two, or possibly three states, where, in coöperation with the state health department, the Fund will aid in the establishment of a field unit to promote rural health service, and in the development of adequate, well-rounded health service in two rural counties or districts. In these same states the Fund will offer each year fifteen scholarships for postgraduate study by rural physicians, and will assist a leading medical school to set up or strengthen courses in preventive medicine and facilities for postgraduate study.

At a meeting of the trustees of the Rockefeller Foundation, Max Mason, Ph.D., formerly president of the University of Chicago, was elected president of the foundation to succeed George E. Vincent, Ph.D., who will retire January 1, having reached the age limit. Dr. Vincent has been president of the foundation since May 15, 1917. Dr. Mason was assistant professor of mathematics at Yale, 1904–1908, and professor of mathematical physics at the University of Wisconsin from 1908 to 1925.

"Reaching the Individual" will be the keynote of the Tenth Annual Ohio State Educational Conference to be held in Columbus, April 3–5, 1930. Programs may be obtained from the Ohio State University.

The Illinois State Nurses Association is preparing to write a history of nursing in Illinois. All Illinois nurses, wherever they are, are asked to send us all material they can. This may include publications, reports, pictures, anecdotes by word of mouth, personal experiences. The source of information should be given.

A contest is planned with prizes ranging from $100 to $5.00 to those sending in the most comprehensive and worthwhile collection. Material should be sent to the Secretary, Mrs. Lucy Van Frank, Room 1504, 116 South Michigan Avenue, who will also give further details of the contest if desired.

(*For recent appointments see page 9 of the Advertising Section.*)

Official Directory

Listing nurses holding executive positions in states and officers of State Organizations for Public Health Nursing and Public Health Nursing Sections of State Graduate Nurses Associations.

The National Organization for Public Health Nursing, Inc.—President, Mrs. Anne L. Hansen, 181 Franklin St., Buffalo, N. Y. Director, Katharine Tucker, 370 Seventh Ave., New York.

Nursing Service, American Red Cross—National Director, Clara D. Noyes, American Red Cross, Washington, D. C.

Public Health Nursing Service, American Red Cross—National Director, Elizabeth G. Fox, American Red Cross, Washington, D. C.

Midwestern Area: Director, Mrs. Elsbeth Vaughan; Assistant Director, Louise Kinney, 1709 Washington Ave., St. Louis, Mo.

Pacific Area: Director, Rena Haig; Assistant Director, Eugenia Klinefelter, Larkin and Grove Sts., San Fancisco, Cal.

Eastern Area: Director, I. Malinde Havey; Assistant Directors, Annabelle Petersen and Myrtie E. Taylor, American Red Cross, Washington, D. C.

Army Nurse Corps, U. S. A.—Superintendent, Major Julia C. Stimson, Dean, Army School of Nursing, Washington, D. C.

Navy Nurse Corps, U. S. N.—Superintendent, J. Beatrice Bowman, Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

U. S. Public Health Service Nurse Corps—Superintendent, Lucy Minnigerode, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

Nursing Service, U. S. Veterans' Bureau—Superintendent, Mrs. Mary A. Hickey, Hospital Section, U. S. Veterans' Bureau, Washington, D. C.

Indian Bureau—Supervisor of Field Nurses and Field Matrons, Elinor D. Gregg, U. S. Department of the Interior, Office of Indian Affairs, Washington, D. C.

Alabama

State Board of Health—Bureau of Child Hygiene and Public Health Nursing, Director, Jessie L. Marriner, 519 Dexter Ave., Montgomery.

American Red Cross Nursing Field Representative—Helen Dunn, American Red Cross, Washington, D. C.

State Graduate Nurses' Association Paid Executive—Linna H. Denny, 1320 N. 25th St., Birmingham.

Arizona

American Red Cross Nursing Field Representative—Mrs. Blanche Cannon, Civic Auditorium, Larkin and Grove Sts., San Francisco.

Arkansas

State Organization for Public Health Nursing—Pres., Eva M. Connor, 4005 W. 13th St., Little Rock. Sec., Esther Foster, 4005 W. 13th St., Little Rock. Treas., Mrs. G. Reagan, 4005 W. 13th St., Little Rock. Chairman Membership Committee, Mrs. Marjory W. Falconer, 910 W. 4th St., Little Rock.

State Board of Health—Bureau of Child Hygiene, Acting Supervisor of Nursing, Mary Emma Smith, Little Rock.

American Red Cross Nursing Field Representative—Etta Lee Gowdy, 1709 Washington Ave., St. Louis, Mo.

California

State Organization for Public Health Nursing—Pres., Alice C. Bagley, 600 Stockton St., San Francisco. Sec., Elizabeth Rohrbach, 1735 Santee St., Los Angeles. Treas., Ellie Jacobson, Department of Education, Pasadena. Chairman Membership Committee, Helen Hartley, 129 So. American St., Stockton.

State Board of Health—Bureau of Child Hygiene, Mary Elizabeth Davis, Supervising Nurse, 336 State Building, San Francisco.

American Red Cross Nursing Field Representative—Mrs. Blanche Cannon, Civic Auditorium, Larkin and Grove Sts., San Francisco.

State Tuberculosis Association Field Nurse—

State Graduate Nurses' Association Paid Executive—Anna C. Jammé, Director at Headquarters, Room 502, 609 Sutter St., at Mason, San Francisco.

Colorado

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mary D. Forbes, 305 Barth Bldg., Denver. Vice-chairman, Mrs. Edith Embury Crane, 414–14th St., Denver. Sec.-Treas., Mrs. Dorothy Lepper, 414–14th St., Denver.

American Red Cross Nursing Field Representative—Elizabeth Reynolds, 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurses—Mary D. Forbes, Ruth E. Phillips, 305 Barth Block, Denver.

Connecticut

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Louise Spence, 144 Golden Hill, Bridgeport. Vice-chairman, Mabel Macdonell, Richmond House, Stamford. Sec.-Treas., Ethel Biggs, 1011 Main St., East Hartford.

State Department of Health—Bureau of Public Health Nursing, Director, Sarah R. Addison, Hartford.

American Red Cross Nursing Field Representative—Sarah Addison, American Red Cross, Washington, D. C.

State Graduate Nurses' Association Paid Executive—Margaret K. Stack, Executive Secretary, 175 Broad St., Hartford.

Delaware

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mrs. Anna Van Wickle Castle, 911 Delaware Ave., Wilmington. Sec., Margaret Butler, 2705 Boulevard, Wilmington.

American Red Cross Nursing Field Representative—Celia P. Houston, American Red Cross, Washington, D. C.

District of Columbia

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mary C. Connor, Instructive Visiting Nurse Association, Star Building, 11th and Pennsylvania Ave., Washington.

District Department of Health—Child Welfare and Hygiene Service, Chief Nurse, Edith B. Aldridge, Washington.

District Tuberculosis Association Field Nurse—Rebecca Sweeney, 1022 Eleventh St., N. W., Washington.

Florida

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mrs. Inez M. Nelson, Court House, Orlando. Secretary, Mrs. Charles Freeman, 201 Goodall Street, Daytona Beach.

State Board of Health—Bureau of Child Hygiene and Public Health Nursing, Director, Mrs. Laurie Jean Reid, Jacksonville.

American Red Cross Nursing Field Representative—Ruth Mettinger, American Red Cross, Washington, D. C.

Georgia

State Organization for Public Health Nursing—Pres., Emma E. Habenicht, 404 Atlanta Bank Building, Atlanta. Sec., Evelyn Dugger, Atlanta. Treas., Mrs. Dorothy Treakle, Savannah. Chairman of Membership Committee, Lillian Alexander, City Board of Health, Atlanta.

American Red Cross Nursing Field Representative—Ruth Mettinger, American Red Cross, Washington, D. C.

State Graduate Nurses' Association Paid Executive—Jane Van de Vrede, Executive Secretary, 101 Forrest Avenue, N. E., Atlanta.

Idaho

State Board of Health—Bureau of Child Hygiene, State Director, Mrs. S. J. Ewen.

American Red Cross Nursing Field Representative—Gladyce Badger, Civic Auditorium, Larkin and Grove Sts., San Francisco, Cal.

State Tuberculosis Association Field Nurse—Mrs. Frances M. Wann, Director of Nursing Activities, Idaho Tuberculosis Association, 320 Boise City National Bank Building, Boise.

Illinois

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Hattie Mae Hurst, Library Building, Joliet. Sec., Hester Nicoles, 695 N. Raynor Ave., Joliet.

State Department of Public Health—Division of Child Hygiene and Public Health Nursing, Leone W. Ware, Chief Supervising Nurse, Springfield.

American Red Cross Nursing Field Representatives—Mrs. Barbara Fletcher (north) and Pearl Laptad (south), 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurse—Alpha Rodenberger, Illinois Tuberculosis and Health Association, 516½ E. Monroe St., Springfield.

Indiana

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mabel Munro, 321 Lincolnway, West, South Bend. Vice-chairman, Faye McFadden, 1405 Vermont St., Fort Wayne.

State Board of Health—Division of Public Health Nursing, Director, Eva F. Mac Dougall, 126 State House Annex, Indianapolis.

American Red Cross Nursing Field Representative—Helen Bean, American Red Cross, Washington, D. C.

State Tuberculosis Association Field Nurse—Mrs. Anna E. Sims, 1219–24 Meyer-Kiser Bank Building, Indianapolis.

State Graduate Nurses' Association Paid Executive—Eugenia Kennedy, 309 Traction Terminal Bldg.. Indianapolis.

Iowa

Section on Public Health Nursing of State Association of Registered Nurses—Chairman, Alma Hartz, Durant. Sec.,

Nan Clack, Division of Maternity and Infant Hygiene, Iowa University, Iowa City.

State Department of Health—Edith S. Countryman, Director, Public Health Nursing, State House, Des Moines.

American Red Cross Nursing Field Representative—Thora Ingbritson, 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurse—Edith S. Countryman, Director of Nursing Service, 518 Frankel Building, Des Moines.

Kansas

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mary C. Bure, Visiting Nurse Association, Room 20, Peoples National Bank Building, Kansas City.

State Department of Health—E. Frederica Beal, Division of Child Hygiene, Topeka.

American Red Cross Nursing Field Representative—Linnie Beauchamp, 1709 Washington Avenue, St. Louis, Mo.

State Tuberculosis Association Field Nurse—Mabel R. Marvin, Kansas Tuberculosis and Health Association, 210 Crawford Bldg., Topeka.

Kentucky

State Organization for Public Health Nursing—Pres., Virginia P. Martin, 227 N. Upper St., Lexington. Sec., Hattie A. Porter, Lexington. Treas., Mrs. Myrtle Applegate, 2051 Sherwood Ave., Louisville. Chairman Membership Committee, Margaret L. East, State Board of Health, Louisville.

State Board of Health—Margaret L. East, Director, Bureau of Public Health Nursing, 532 W. Main St., Louisville.

American Red Cross Nursing Field Representative—Helen Dunn, American Red Cross, Washington, D. C.

State Tuberculosis Association Field Nurse—Margaret L. East, 532 West Main St., Louisville.

State Association Paid Executive—Flora E. Keen, Executive Secretary, C-1 Thierman Apartments, 416 W. Breckenridge St., Louisville.

Louisiana

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Maud Reid, Lake Charles. Sec., Emma Maurin, New Court House, New Orleans.

American Red Cross Nursing Field Representative—Helen Dunn, American Red Cross, Washington, D. C.

State Board of Health—Emma Maurin, Field Supervisor of Nurses, Bureau of Parish Health Administration, New Court House, New Orleans.

Maine

Section on Public Health Nursing of State Nurses' Association—Chairman of Public Health, Edith L. Soule, State Department of Health, Augusta. Chairman of School Section, Laura Knowlton, 19 Pleasant St., Augusta.

State Department of Health—Division of Public Health Nursing and Child Hygiene, Director, Edith L. Soule, Augusta.

American Red Cross Nursing Field Representative—Laura Knowlton, American Red Cross, Washington, D. C.

State Tuberculosis Association Field Nurse—Mrs. Theresa R. Anderson, Maine Public Health Association, 256 Water St., Augusta.

Maryland

State Organization for Public Health Nursing—Pres., Mrs. Ethel Monroe Troy, 4417 Wentworth Road, Baltimore. Sec., Grace B. Ridgaway, City Health Department, Baltimore. Treas., Mrs. Ethelyn Dever, City Health Department, Baltimore.

American Red Cross Nursing Field Representatives—Cecilia Houston (east) and Helen M. Erskine (west), American Red Cross, Washington, D. C.

State Tuberculosis Association Field Nurse.—Mattie M. Smith, 900 St. Paul St., Baltimore.

State Association Paid Executive—Sarah F. Martin, Executive Secretary, 1211 Cathedral St., Baltimore.

Massachusetts

Section on Public Health Nursing of State Nurses' Association—Chairman, Eva S. Waldron, Visiting Nurse Association, Springfield. Vice-chairman, Debora Williams, Visiting Nurse Association, Fitchburg. Sec., Anna K. Donovan, State Department of Public Health, Boston.

State Department of Public Health—Division of Child Hygiene: Mary P. Billmeyer, Department Consultant in Public Health Nursing.

American Red Cross Nursing Field Representative—Mildred Whiting, American Red Cross, Washington, D. C.

State Graduate Nurses' Association Paid Executive—Helene G. Lee, 420 Boylston St., Boston.

Michigan

Section on Public Health Nursing of State Graduate Nurses' Association—Pres., Mrs. Lucile Veits, 401 Weller St., Flint. Sec., Mildred Cardwell, R.F.D. No. 3, Lansing.

State Department of Health—Bureau of Child Hygiene and Public Health Nursing, Assistant Director, Mrs. Helen DeSpelder Moore, Lansing.

American Red Cross Nursing Field

Representative—Mrs. Barbara Fletcher, 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurses—Mrs. Ethel Langenberg (tuberculosis nursing), Helen Altvater (school nursing), Beatrice Ferriby (child health education), Michigan Tuberculosis Association, 535 South Capitol Avenue, Lansing.

State Graduate Nurses' Association Paid Executive—Mary C. Wheeler, Capitol Loan and Savings Bank Building, 118 E. Allegan St., Lansing.

Minnesota

State Organization for Public Health Nursing—Pres., Eula B. Butzerin, University of Minnesota, Minneapolis. Sec., Jean Taylor, 404 So. 8th St., Minneapolis. Treas., Margaret McGregor, 1003 Ivy St., St. Paul. Chairman of Membership Committee, Eleanor W. Mumford, 2432 Bryant St., S., Minneapolis.

State Department of Health—Division of Child Hygiene, Superintendent of Public Health Nursing, Olivia Peterson, University Campus, Minneapolis.

American Red Cross Nursing Field Representative—Eleanor W. Mumford, 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurses—Edith Ross and Mabel Johnson, Minnesota Public Health Association, 11 West Summit Ave., St. Paul.

State Graduate Nurses' Association Paid Executive—Caroline M. Rankiellour, 148 Summit Ave., St. Paul.

Mississippi

Section on Public Health Nursing of State Nurses' Association—Chairman, Mary D. Osborne, Old Capitol Building, Jackson.

State Board of Health—Bureau of Child Hygiene and Public Health Nursing, Mary D. Osborne, Supervisor, Public Health Nursing and Maternal and Infant Hygiene, Jackson.

American Red Cross Nursing Field Representative—Helen Dunn, American Red Cross, Washington, D. C.

Missouri

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Anna Heisler, 216 S. Kingshighway, St. Louis. Sec., Marie Brockman, 3449-a Crittenden St., St. Louis.

State Board of Health—Division of Child Hygiene, Pearl McIver, Director of Public Health Nursing, Jefferson City.

American Red Cross Nursing Field Representative—Pearl Laptad, 1709 Washington Ave., St. Louis.

State Tuberculosis Association Field Nurse—Martha Sander, Missouri Tuberculosis Association, 2221 Locust St., St. Louis.

Montana

American Red Cross Nursing Field Representative — Bessie Nicoll, 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurses—Alta Walls and Alma Wrestling, Montana Tuberculosis Association, Helena.

Nebraska

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Augusta Eklund, 620 Arthur St., Holdredge. Sec., Elizabeth Brown, Box 315, McCook.

American Red Cross Nursing Field Representative—Elizabeth Reynolds, 1709 Washington Ave., St. Louis, Mo.

Nevada

State Tuberculosis Association Field Nurse—Luciele A. Withers, P. O. Box 216, Las Vegas.

New Hampshire

State Department of Health—Division of Maternity, Infancy and Child Hygiene, Mrs. Mary D. Davis, Supervising Nurse and Director, Concord.

State Board of Education—Elizabeth Murphy, Supervisor of Health, Concord.

American Red Cross Nursing Field Representative—Myrtle Flanders, American Red Cross, Washington, D. C.

New Jersey

State Organization for Public Health Nursing—Pres., Anna Ewing, 292 Broad St., Newark. Rec. Sec., Hettie W. Seifert, Court House, Elizabeth. Sec., Mary A. Weir, 3027 N. Congress St., Camden. Treas., Mary E. Edgecomb, Englewood Hospital, Englewood. Chairman Membership Committee, Grace Remshard, 203 Broad St., Newark.

State Department of Health—Bureau of Child Hygiene: Grace P. Remshard, Assistant in Charge of Midwifery; Alice F. Boyer, Supervisor of Nurses; Mary R. Sullivan, Assistant in Charge of Boarding Home—State House, Trenton.

American Red Cross Nursing Field Repsesentative—Mrs. Belle Wagner, American Red Cross, Washington, D. C.

State Graduate Nurses' Association Paid Executive—Arabella Creech, 42 Bleecker St., Newark.

New Mexico

State Organization for Public Health Nursing—Pres., Ella Yeager, Roswell. Vice-Pres., Edna Schiernberg, Las Cruces. Sec.-Treas., Edith Hodgson, Santa Fe.

State Board of Health—Division of Child Hygiene and Public Health Nursing, Chief, Edith Hodgson, Bureau of Public Health, Santa Fe.

American Red Cross Nursing Field Representative—Elizabeth Reynolds, 1709 Washington Ave., St. Louis, Mo.

New York

State Organization for Public Health Nursing—Pres., Marion W. Sheahan, State Department of Health, Albany. Sec., Dorothy Wise, Visiting Nurse Association, Syracuse. Treas., Mrs. Tessa M. Klein, Visiting Nurse Association, Buffalo. Chairman Membership Committee, Mrs. Katherine Johnson, 10 Second St., Gloversville.

State Department of Health—Division of Public Health Nursing, Director Mathilde S. Kuhlman, Albany.

American Red Cross Nursing Field Representative—Mrs. Charlotte Heilman, American Red Cross, Washington, D. C.

State Tuberculosis Association Field Nurse—Mrs. Bessie P. Hanson, Field Nurse, State Charities Aid Association, 105 East 22nd St., New York.

State Graduate Nurses' Association Paid Executive—Emily J. Hicks, N. Y. State Nurses Association, 370 Seventh Ave., New York.

North Carolina

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Lucia Freeman, Box 901, Fayetteville. Vice-chairman, Martha Thorpe, Health Department, Charlotte. Sec., Maude Seitzer, Health Department, Asheville.

State Board of Health—Draper Fultz, Supervising Maternity and Infancy Nurse, Raleigh.

American Red Cross Nursing Field Representative—Mary DeLaskey, American Red Cross, Washington, D. C.

State Graduate Nurses' Association Paid Executive—Mary P. Laxton, Executive Secretary, 16 Howland Road, Asheville.

North Dakota

American Red Cross Nursing Field Representative—Bessie Nicoll, 1709 Washington Ave., St. Louis, Mo.

Ohio

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mrs. Louise K. Tooker, 934 Clark St., Cincinnati. Vice-chairman, Sue Z. McCracken, 1201 Cranford Ave., Cleveland. Sec., Anna M. Doyle, Public Health League, Hamilton.

State Health Department—Division of Public Health Nursing, Mrs. Zoe McCaleb, Chief, 246 N. High St., Columbus.

American Red Cross Nursing Field Representative—Julia Groscop, American Red Cross, Washington, D. C.

State Association Paid Executive—Mrs. Elizabeth P. August, Executive Secretary, 83 E. Gay St., Columbus.

Oklahoma

State Organization for Public Health Nursing—Pres., Luis G. Todd, Health Center, Pawhuska. Sec., Blanche Eddy, 410 So. Cincinnati, Tulsa. Treas., Edna Ashenhurst, City Hall, Oklahoma City. Chairman Membership Committee, Mrs. Myrtle Conn, 1710 Euclid Ave., Oklahoma City.

State Department of Public Health—Bureau of Maternity and Infancy, Supervising Nurse, Golda B. Slief, 526 State Capitol Building, Oklahoma City. Bureau of Dental Health Education, Director, Pearl E. Wilson.

American Red Cross Nursing Field Representative—Etta Lee Gowdy, 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurse—Bess Killough, Oklahoma Public Health Association, 22 W. 6th St., Oklahoma City.

Oregon

State Organization for Public Health Nursing—Pres., Mae Dwyer, Bureau of Health, Portland. Sec., Ethel I. Gunderson, 106 Floral Ave., Portland. Treas., Mildred Halvorsen, 303 Fitzpatrick Building, Portland. Chairman Membership Committee, Mary F. Nadeau, 170 Vista Ave., Portland.

State Board of Health—Bureau of Public Health Nursing, Mrs. Glendora Blakely, State Advisory Nurse, Portland.

American Red Cross Nursing Field Representative—Gladyce Badger, Civic Auditorium, Larkin and Grove Sts., San Francisco, Cal.

State Tuberculosis Association Field Nurses—Demonstration Nurses: Margaret Gillis, and Edna Flanagan, 310 Fitzpatrick Block, Portland.

Pennsylvania

State Organization for Public Health Nursing—Pres., Helen M. Erskine, 613 Philadelphia Ave., Chambersburg. Sec., Esther R. Entriken, 815 Mechanics Trust Building, Harrisburg. Treas., Mrs. J. Pryor Williamson, Wilkes-Barre. Chairman Membership Committee, Jessie Cunningham, 61 W. Union St., Wilkes-Barre.

State Department of Health—Bureau of Nursing, Alice M. O'Halloran, Chief, Harrisburg.

State Department of Public Instruction—Supervisor of School Nursing, Mrs. Lois Owen, Harrisburg.

American Red Cross Nursing Field Representatives—Celia P. Houston (east) and Helen M. Erskine (west), American Red Cross, Washington, D. C.

State Tuberculosis Association Field Nurse—Lilah L. Curry, Pennsylvania Tuberculosis Society, 311 S. Juniper St., Philadelphia.

State Graduate Nurses' Association Paid Executive—Esther Entriken, Executive Secretary, 400 N. Third St., Harrisburg.

Rhode Island

State Organization for Public Health Nursing—Pres., Anna M. Stanley, 118 N. Main St., Providence. Sec., Cecelia Walsh, 118 N. Main St., Providence. Treas., Agnes Davis, 118 N. Main St., Providence. Chairman Membership Committee, Bertha E. Jutras, 118 N. Main St., Providence, R. I.

American Red Cross Nursing Field Representative—Mildred Whiting, American Red Cross, Washington, D. C.

South Carolina

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Nellie C. Cunningham, State Board of Health, Columbia.

State Board of Health—Bureau of Child Hygiene and Public Health Nursing, Nellie C. Cunningham, Director, State Office Building, Columbia.

American Red Cross Nursing Field Representative—Mary DeLaskey, American Red Cross, Washington, D. C.

State Tuberculosis Association Field Nurse—Virginia Anderson, 1218 Senate St., Columbia.

South Dakota

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Nelle Petterson, Sioux Falls. Vice-Chairman, Mabel Helstab, Howard. Secretary, Anna Dailey, Webster.

State Board of Health—Division of Child Hygiene, Florence E. Walker, Director of Public Health Nursing and Division of Child Hygiene, Waubay.

American Red Cross Nursing Field Representative—Bessie Nicoll, 1709 Washington, Ave., St. Louis, Mo.

Tennessee

Section on Public Health Nursing of State Graduate Nurses' Association—State Committee: State Chairman, Lucille Satterfield, 234 Foster Ave., Nashville; Malvinia G. Nisbit, State Health Department, Nashville; Mrs. Birdie Cawthorn, District No. 1, City Health Department, Memphis; Fannie Titsworth, District No. 2, Knox County Court House, Knoxville.

State Department of Health—Malvinia G. Nisbet, State Supervisor of Nurses, Nashville.

American Red Cross Nursing Field Representative—Helen Dunn, American Red Cross, Washington, D. C.

Texas

State Organization for Public Health Nursing—Pres., Mary Kennedy, 518 Keystone Building, Houston. Sec.-Treas., Katherine Hagquist, State Board of Health, Austin. Chairman Membership Committee, Mrs. Zula L. Powell, 320 Cotton Exchange Bldg., Ft. Worth.

State Board of Health—Bureau of Maternity and Child Hygiene, Katherine Hagquist, State Supervisor of Nurses, Austin.

American Red Cross Nursing Field Representative—Mrs. Myra Cloudman, 1709 Washington, Ave., St. Louis.

State Tuberculosis Association Field Nurse—Jean M. Campbell, Texas Public Health Association, 616 Littlefield Bldg., Austin.

State Graduate Nurses' Association Paid Executive—A. Louise Dietrich, 1001 E. Nevada St., El Paso.

Utah

State Organization for Public Health Nursing—Pres., Dora Maiben, 18 Craig Apartments, Salt Lake City. Sec., Ellen McDonald, 1051 Bryan Ave., Salt Lake City. Treas., Louise Van El, 158 William St., Salt Lake City. Chairman Membership Committee, Emma Bradley, Veba School District, Spanish Fork.

State Tuberculosis Association Field Nurse—Frances Delk, 517 Vermont Building, Salt Lake City.

Vermont

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Mrs. Helen Armstrong, 102½ Church St., Burlington.

State Board of Health—Nellie N. Jones, Field Nurse, Promotion of the Welfare and Hygiene of Maternity and Infancy, 41 Franklin St., Box 347, Brandon.

American Red Cross Nursing Field Representative—Alice Petersen, American Red Cross, Washington, D. C.

Virginia

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Robina Kneebone, 827 W. Franklin St., College of William and Mary, Richmond.

State Board of Health—Nannie J. Minor, Director of Public Health Nursing, Richmond.

American Red Cross Nursing Field Representative—Alice Dugger, American Red Cross, Washington, D. C.

Washington

State Organization for Public Health Nursing—Pres., Edna Mason, 808 W. 25th St., Spokane. Sec., Elizabeth Hazard, Y.W.C.A. Building, Seattle. Treas., Minerva Blegan, Court House, Spokane. Chairman Membership Committee, Olga Gaplen, 2404 W. 2nd Ave., Spokane.

State Department of Health—Division of Public Health Nursing and Child Hygiene, Mrs. Mary Louise Allen, Chief, Seattle.

American Red Cross Nursing Field Representative — Gladyce Badger, Civic Auditorium, Larkin and Grove Sts., San Francisco, Cal.

State Graduate Nurses' Association Paid Executive—Cora E. Gillespie, Executive Secretary, 327 Cobb Building, Seattle.

West Virginia

Section on Public Health Nursing of State Graduate Nurses' Association—Chairman, Elizabeth C. Lowery, Logan. Vice-Chairman, Mrs. Wayne Welton Gadd, State Department of Health, Charleston. Sec., Marion D. Bell, Marion County Health Unit, Fairmont.

American Red Cross Nursing Field Representative—Julia Groscop, American Red Cross, Washington, D. C.

State Tuberculosis Association Field Nurses—Mary V. Gill and Sylvia Kardaras, West Virginia Tuberculosis and Health Association, 910 Quarrier St., Charleston.

Wisconsin

Section on Public Health Nursing of State Graduate Nurses' Association—(Pending.)

State Board of Health—Bureau of Public Health Nursing, Cornelia Van Kooy, Director of Public Health Nursing, Madison.

American Red Cross Nursing Field Representative — Eleanor Mumford, 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurses—Doris Kerwin and Mrs. Pearl Stephenson, Wisconsin Anti-Tuberculosis Association, 558 Jefferson St., Milwaukee.

Wyoming

Section on Public Health Nursing of State Graduate Nurses' Association.

American Red Cross Nursing Field Representative—Bessie Nicoll, 1709 Washington Ave., St. Louis, Mo.

State Tuberculosis Association Field Nurse—Edith Stallard, Wyoming Public Health Association, 534 Boyd Building, Cheyenne.

TERRITORIAL POSSESSIONS

Hawaii

Territorial Board of Health—Mabel L. Smyth, Director of Maternal and Infant Hygiene Division, and Supervising Nurse, Honolulu.

Insular Tuberculosis Association—Stella S. Matthews, Director of Tuberculosis Nurses, Palama Settlement, 1361 Palama St., Honolulu.

Anti-Tuberculosis Association—Secretary, Mabel I. Wilcox, Lihue. Public Health Nurses: Ethel M. Greathouse, Florence B. Geyer.

Panama Canal Zone

Health Department, The Panama Canal—Ethel A. Fitch, Chief Nurse, Gorgas Hospital, Ancon. Lilliam M. Ham, Chief Nurse, Corozal Hospital, Corozal. Winifred D. Shea, Chief Nurse, Colon Hospital, Cristobal.

Philippine Islands

American Red Cross Nursing Field Representative — Pansy Besom, American Red Cross, Manila.

Philippine Health Service—Public Health Nursing Division, Genera S. Manongdo, Chief Nurse, Manila.

Philippine General Hospital—Enriqueta Macaraig, Chief Nurse and Superintendent, Manila; Rosa Militar, Principal, School of Nursing, Manila.

Office of Public Welfare Commission—Socorro Salamanca Diaz, Superintendent of Nurses' Service, Manila.

Porto Rico

Head Nurses at Dispensaries of Child Hygiene, Maternity and Tuberculosis—Pauline R. Dávila, Santurce. Mrs. Rosa Reyes de Oliveras, Local Health Office, San Juan. Mrs. Ana M. Otero, Barrio. Mrs. Lizzie Branderberger, Juncos. Joaquina Couvertie, Humacoa. Teresa Ventura, Ponce. Cecile Carriere, Mayaguez. Mrs. Justa Sánchez de Alamo, Carolina. Mrs. Dominga O. de Bonini, Catano. Carmen Sanchez, Guayama. Dolores Irizarri, Caguas. Armanda Noriega, Yabucoa. Ana Beltrán.

Dispensary of Social Hygiene, Puerta de Tierra—Felicita Trujillo, Quarantine Hospital, San Juan. Mariana Reyes, Insular Tuberculosis Sanatorium, Rio Piedras. Miss Roche, Anti-Tuberculosis League Sanatorium, Ponce. Miss MacKannon, Instructor of Nurses, Public Health Unit, Rio Piedras.

Metropolitan Life Insurance Company Nursing Supervisors—Mrs. Helen C. La Malle, Supt. of Nursing, No. 1 Madison Ave., New York City.

Margaret E. Kearney, Ass't Supt. of Nursing, No. 1 Madison Ave., New York City.

Alice Bagley, Ass't Supt. of Nursing, 600 Stockton St., San Francisco, Calif.

Alice Ahern, Ass't Supt. of Nursing, 180 Wellington St., Ottawa, Ont., Canada.

Miss Maude E. Steeves, Ass't Supt. of Nursing, No. 1 Madison Ave., New York City.

Territorial Supervisors and Territory

L. Carey Jones, 833 Hurt Building, Edgewood Ave., and Exchange Place, Atlanta, Ga.: No. Carolina, So. Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana.

Isabelle Carruthers, 1319 Ambassador Bldg., St. Louis, Mo.: Missouri, Kansas, Oklahoma, Arkansas, Tennessee.

Ellen Atchison, 1142 Book Tower Bldg., Detroit, Mich.: Michigan, Wisconsin, Minnesota, Nebraska, Iowa.

Carolyn M. Hidden, 1105 Bankers Trust Bldg., Philadelphia, Pa.: Pennsylvania.

Monica Moore, 425–426 Munsey Bldg., Fayette and Calvert Sts., Baltimore, Md.: New Jersey, Delaware, Maryland, Virginia, District of Columbia.

Sara O'Meara, 1104 Home Savings Bank Bldg., 11 No. Pearl St., Albany, N. Y.: New York State (except Westchester County), Maine, New Hampshire, Vermont.

Mrs. Minnie Cunningham, 1007 Waterman Bldg., 44 School Street, Boston, Mass.: Massachusetts, Connecticut, Rhode Island.

Ruth King, Room 1123, Chamber of Commerce Building, Cincinnati, Ohio: Ohio, Kentucky, West Virginia.

Irene L. Harris, Room 601 Lake Michigan Bldg., 180 No. Michigan Ave., Chicago, Ill.: Illinois, Indiana.

Local Supervisors

Mary Harrigan, 26 Journal Square, Jersey City Heights, N. J.

Grace Anderson, 143 East State St., Trenton, N. J.

Teresa O'Neil, Shorn Bldg., 148–15 Archer Ave., Jamaica, Long Island.

Mrs. Helen Dorian, 415 Taylor Building, 328 E. Main St., Rochester, N. Y.

Anna Barr, 210 Baronne St., New Orleans, La.

Emma Habenicht, 403–404 Atlanta Nat'l Bank Bldg., Atlanta, Ga.

Edna Lynch, 484 McGill St., Rm. 34, Montreal, Canada.

Irma VanBockstade, 294 St. Catherine St., E., Montreal, Canada.

Elizabeth Rohrback, Clearing House, 357 South Hill St., Los Angeles, Cal.

Miss Agnes Leahy, 89 E. Fifth St., St. Paul, Minn.

Emma Rocque, 4503 St. Denis St., Apt. 3, Montreal, Canada.

Emily Fitzpatrick, 39 St. Johns St., Quebec, Canada.

Mrs. Cameron King, 950 S. Pacific Ave., Tacoma, Wash.

Miss Margaret Leddy, Nurse in charge—709 Wilson Bldg., B'way and Cooper St., Camden, N. J.

Field Supervisor

Matilda Johnson, Room 601 Lake Michigan Bldg., 180 North Michigan Ave., Chicago, Ill.

Group Supervisor

Mary J. Horn, Room 1200, 134 North LaSalle St., Chicago, Ill.

Educational Supervisor

Mary C. Dickerman, 26 Journal Square, Jersey City, New Jersey.

John Hancock Mutual Life Insurance Company Nursing Supervisors—Director, Sophie C. Nelson, Boston, Mass.

Assistant Director. Miriam Ames, Boston, Mass.

Assistant to the Director, Agnes V. Murphy, Boston, Mass.

Assistant to the Director, Katharine E. Peirce, Boston, Mass.

Local Supervisor, Helen U. Carew, Post Office Building, 92–30 Union Hall St., Jamaica, Long Island, N. Y.

APPOINTMENTS

Marion Lowe as Industrial Nurse, Union Carbide Company, New York, N. Y.

Anne Spangler as Assistant Nurse, City Department of Health, Port Chester, N. Y.

Delia Shanahan to the staff of the Out-Patient Department, St. Mary's Hospital, Brooklyn, N. Y.

Olga Buresh, formerly County Public Health Nurse in Brazoria County, Texas, was recently appointed State Itinerant Nurse.

Lucy E. Ramstead as County Public Health Nurse, Cooke County, Texas.

Mabel B. Davis as County Public Health Nurse, Limestone County, Texas.

Lucia Pfluger as County Public Health Nurse, Pecos County, Texas.

Lula A. Davis has accepted a position with the United States Public Health Service.

Emily Lammons as Public Health Nurse, Hidalgo County Health Unit, Texas.

Frances Mayfield as Public Health Nurse, Williamson County, Texas.

The Joint Vocational Service reports the following information on placements:

Bertha Beers, recently Assistant Director, Visiting Nurse Association, Newark, N. J., as District Supervising Nurse and Maternity-Infancy Consultant for Long Island under the New York State Department of Health.

Mary P. Billmeyer as Nurse Consultant for the Massachusetts State Department of Health.

Caroline Smith, formerly a supervisor in the Out-Patient Department of the University Hospital, Omaha, Nebraska, as Educational Supervisor, Public Health Nursing Council, Nashville, Tenn.

Irene Donovan as Supervisor in the Instructive Visiting Nurse Society, Washington, D. C.

Nellie Winey as Community Nurse, Ossining, N. Y.

Winifred Fenton as Advisory Nurse, Metropolitan Life Insurance Company, New York City.

Katherine Luby, for the past five years in service with the U. S. Public Health Service at Panama Canal, to the Indian Service with assignment at Pima, Arizona.

Mary G. Young, recently Supervisor in Henry Street Visiting Nurse Service, as Supervisor in the Visiting Nurse Association, Newark, N. J.